

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.5

Submitted by:

Division of Medical Assistance
North Carolina Department of Health and Human Services

Submission Date:

CMS Receipt Date (CMS Use)

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment) Include population served and broad description of the waiver program:

Brief Description:

This is a request to renew the North Carolina Piedmont Innovations HCBS Waiver (CMS Control #0423.01), effective April 1, 2008. The Innovations Waiver supports people with intellectual and other developmental disabilities in a five-county service area.

State:	Piedmont North Carolina
Effective Date	April 1, 2008

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

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1. Request Information

A. The **State** of **North Carolina** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Waiver Title** (optional): **Piedmont Innovations Waiver**

C. **Type of Request** (select only one):

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	Attachment #1 contains the transition plan to the new waiver.		
<input checked="" type="radio"/>	Renewal (5 Years) of Waiver #	0423.01	
<input type="radio"/>	Amendment to Waiver #		

D. **Type of Waiver** (select only one):

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver , as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** **April 1, 2008**

E.2 **Approved Effective Date** (CMS Use):

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (check each that applies):

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input type="checkbox"/>	Nursing Facility (select applicable level of care)
<input type="radio"/>	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input checked="" type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

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G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities (*check the applicable authority or authorities*):

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input checked="" type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i> Innovations operates concurrently with the Piedmont Cardinal Health Plan, waiver number NC 02.RO1, which was renewed effective April 1, 2007 through March 31, 2009.		
	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input checked="" type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input checked="" type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program operated under §1932(a) of the Act. <i>Specify the nature of the State Plan benefit and indicate whether the State Plan Amendment has been submitted or previously approved.</i>		
<input type="checkbox"/>	A program authorized under §1915(j) of the Act		
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
<input type="checkbox"/>	Not applicable		

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

The Piedmont Innovations 1915(c) Home and Community-Based Services Waiver (HCBS) program for individuals with intellectual disabilities and other developmental disabilities operates concurrently with the 1915(b) Piedmont Cardinal Health Plan. Innovations services and supports are available to individuals who, for the purposes of Medicaid eligibility, are residents of Cabarrus, Davidson, Stanly, Rowan and Union counties. The Piedmont Cardinal Health Plan functions as a Prepaid Inpatient Health Plan (PIHP) through which all mental health, substance abuse and developmental disability services are authorized for Medicaid beneficiaries in the five-county area.

Purpose: The Innovations Waiver is designed to provide an array of community based services and supports that promote choice, control and community membership. These services provide a community based alternative to institutional care for persons who require an ICF-MR level of care.

Goals and Objectives :

- (1) To value and support waiver participants to be fully functioning members of their community;
- (2) To promote Promising Practices that result in real life outcomes for participants;
- (3) To offer service options that will facilitate each participant's ability to live in homes of their choice, have employment or engage in a purposeful day of their choice and achieve their life goals;
- (4) To provide the opportunity for all participants to direct their services to the extent that they choose;
- (5) To provide educational opportunities and support to foster the development of stronger natural support networks that enable participants to be less reliant on formal support systems.

Organizational Structure: The North Carolina Division of Medical Assistance (DMA), the single State Medicaid agency, operates the Innovations Waiver. DMA contracts with Piedmont Behavioral Health (PBH) to arrange for and manage the delivery of services and perform other waiver operational functions under the concurrent 1915(b)/1915(c) waivers. PBH is a MH/DD/SAS local management entity (LME), a multi-county political subdivision of the State of North Carolina that is established and operates in accordance with NC General Statute 122C (GS 122C-116). DMA directly oversees the Innovations Waiver, approve all policies and procedures governing waiver operations and ensures that 1915(c) waiver assurances are met.

Service Delivery Methods: All Innovations waiver services are authorized through the annual Individual Service Plan which is developed using person-centered planning methods. Waiver participants may select any qualified PBH network provider to furnish authorized services. Innovations offers both Employer and Budget Authorities to participants who elect to direct their own services. Orientation to participant direction is offered to all waiver participants upon entrance to the waiver and annually thereafter during Individual Support Plan development. To facilitate the ability of the PIHP to focus Innovations waiver funding on moving the current residential system to a system focused on small private or community based facilities, an amendment to the concurrent 1915(b) waiver will be requested to use 1915(b)(3) service funds to support individuals who choose to remain in facilities larger than 3 beds. Innovations participants who live in facilities greater than 3 beds will have the choice to receive services under the B-3 option.

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3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** **Appendix A** specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** **Appendix B** specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** **Appendix C** specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** **Appendix D** specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, **Appendix E** specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input checked="" type="radio"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="radio"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>
- F. Participant Rights.** **Appendix F** specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** **Appendix G** describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** **Appendix H** contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** **Appendix I** describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** **Appendix J** contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a) (10) (B) of the Act in order to provide the services specified in **Appendix C** that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in **Appendix B**.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a) (10) (C) (i) (III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input checked="" type="radio"/>	Yes
<input type="radio"/>	No
<input type="radio"/>	Not applicable

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- C. State wideness.** Indicate whether the State requests a waiver of the state wideness requirements in §1902(a) (1) of the Act (*select one*):

<input checked="" type="radio"/>	Yes (<i>complete remainder of item</i>)
<input type="radio"/>	No

If yes, specify the waiver of state wideness that is requested (*check each that applies*):

<input checked="" type="checkbox"/>	Geographic Limitation. A waiver of state wideness is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
	The waiver serves individuals who are legal residents for the purpose of Medicaid eligibility of the following counties: Cabarrus, Davidson, Rowan, Stanly and Union counties.
<input type="checkbox"/>	Limited Implementation of Participant-Direction. A waiver of state wideness is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 - Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 - Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.
- Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b) (1) (i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

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participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b) (1) (ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a) (2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

A variety of mechanisms were utilized to gain public input. Participant focus groups were held in each of the five counties. Meetings were held with advocates for persons with intellectual and other developmental disabilities, stakeholder agencies, provider agencies and other interested parties to gain input concerning waiver design and service array. Comments received were posted on the PIHP website and served as the basis of an educational Q&A document. The draft waiver application was posted for public comment for a 30 day period commencing in October 2007. A notice to the Eastern Band of the Cherokee regarding the Innovations waiver renewal was sent in late September.

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- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Judy
Last Name	Walton
Title:	Program Administrator
Agency:	Division of Medical Assistance, NCDHHS
Address 1:	2501 Mail Service Center
Address 2:	
City	Raleigh
State	NC
Zip Code	27699-2501
Telephone:	919-855-4111
E-mail	Judy.walton@ncmail.net
Fax Number	919-715-4715

- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are **readily** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____

Date: _____

State Medicaid Director or Designee

First Name:	William
Last Name	Lawrence
Title:	Acting Director
Agency:	Division of Medical Assistance, NCDHHS
Address 1:	2501 Mail Service Center
Address 2:	
City	Raleigh
State	NC
Zip Code	27699-2501
Telephone:	919-855-4100
E-mail	
Fax Number	919-733-6608

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Appendix A: Waiver Administration and Operation

1. **State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

<input checked="" type="radio"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one; do not complete Item A-2</i>):	
	<input checked="" type="radio"/> The Medical Assistance Unit (<i>name of unit</i>):	The Division of Medical Assistance, NC Department of Health and Human Services
	<input type="radio"/> Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (<i>name of division/unit</i>). This includes administrations/divisions under the umbrella agency that has been identified as the Single State Medicaid Agency. <i>Complete item A-2</i>	
<input type="radio"/>	The waiver is operated by _____ a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. <i>Complete item A-3.</i>	

2. **Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (*select one*):

<input checked="" type="radio"/>	<p>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i></p> <p>Innovations operates concurrently with the Piedmont Cardinal Health Plan, a 1915(b) waiver that provides for the delivery of all mental health, developmental disabilities and substance abuse (MH/DD/SA) services, including Innovations waiver services, to Medicaid beneficiaries in the five-county service area. Piedmont Behavioral Health functions as the single prepaid inpatient health plan (PIHP) for the concurrent waivers. All Medicaid MH/DD/SA services, including Innovations waiver services, are authorized by and provided through the PIHP in accordance with the risk contract between the Division of Medical Assistance (DMA) and the PIHP. The contract requires the PIHP to conduct the following operational and administrative activities: all utilization management and prior approval activities, level of care determinations, provider network credentialing and enrollment, and provider reimbursement. DMA also contracts with an agency to function as the External Quality Review Organization (EQRO) for the concurrent waivers.</p>
<input type="radio"/>	No. Contracted entities do not perform waiver operational and administrative functions on

behalf of the Medicaid agency and/or the operating agency (if applicable).

3. **Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the functions that are expressly delegated through a memorandum of understanding (MOU) or other written document, and indicate the frequency of review and update for that document. Specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

N/A

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*check each that applies*):

<input type="checkbox"/>	Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i>
<input checked="" type="checkbox"/>	Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i>
	The prepaid inpatient health plan (PIHP) described in A.2 above is a regional non-governmental, non-state area authority which has, by state statute, certain oversight and coordination responsibilities for publicly funded MH/DD/SA services .
<input type="checkbox"/>	Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions.

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

The Division of Medical Assistance along with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services within the Department of Health and Human Services are responsible for assessing the performance of the PIHP in conducting operational and administrative functions.

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

This waiver operates concurrently with the Piedmont Cardinal Health Plan 1915(b) waiver. Performance expectations and methods of evaluation and oversight by the State, which are summarized below, are delineated in the risk contract between the State Medicaid agency and the PIHP.

Oversight of the concurrent waivers is performed by an Intra-Departmental Monitoring Team (IMT) with representation from all divisions within the Department of Health and Human Services involved in the operation of the 1915(b)/(c) waivers. The IMT meets quarterly with DMA leading the team. At these quarterly meetings, the PIHP reports to the IMT on internal quality assurance/improvement activities such as consumer and provider surveys, performance measures, complaints and grievances and other issues or concerns that affect service delivery. The team provides feedback and implements corrective action plans as needed. The IMT also conducts an annual on-site review of the PIHP operations. The team reviews overall PIHP operations, including utilization and care management, clinical direction, executive management, claims processing, financial management, information systems and reporting. A written report of findings is generated and a plan of correction for deficiencies is implemented if needed. Progress with the plan of correction is tracked by the IMT quarterly.

DMA requires quarterly and annual statistical reporting on service utilization and access to care. DMA also requires quarterly complaints and grievance reports, and takes corrective action as needed.

DMA contracts with an External Quality Review Organization (EQRO), as required by Federal managed care regulations, to evaluate the PIHP's compliance with the quality assurance standards outlined in the risk contract. The review is conducted once during each two-year 1915(b) waiver period and consists of both a desk top review and an on-site visit.

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- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct an administrative function, it supervises the performance of the function and establishes and/or approves policies that affect the function. All functions not performed directly by the Medicaid agency must be delegated in writing and monitored by the Medicaid Agency.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity
Level of care evaluation activities	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prior authorization of waiver services	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Medicaid provider agreements	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Establishment of a statewide rate methodology	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rules, policies, procedures and information development governing the waiver program	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment managed against approved limits	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver expenditures managed against approved levels	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Quality assurance and quality improvement activities	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Participant service plans	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Utilization management functions	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Enroll all willing and qualified providers	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Waiver enrollment	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Quality Management: Administrative Authority of the Single State Medicaid Agency

As a distinct component of the State's quality management strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery:

a.i For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

Performance Measure:	The PIHP implements and reports on the performance measures as required throughout this application regarding waiver assurances and sub-assurances in the areas of level of care; qualified provider; service plan development, implementation and monitoring; consumer health and welfare, and financial accountability.		
Data Source: Reports to State Medicaid Agency from PIHP	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify: As specified for each performance measure in this document.	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Other: Specify: As	

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		<i>specified for each performance measure in this document.</i>	

Performance Measure:	<i>The PIHP implements corrective action plans as required and approved by DMA for problems/deficiencies identified through performance measure reporting, on-site reviews, record reviews, EQRO and Independent Assessment findings and other oversight activities.</i>		
Data Source: Reports to State Medicaid Agency from PIHP	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify: As problems are detected and corrective action plans implemented	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

Performance Measure:	<i>DMA conducts monitoring of the PIHP corrective action plans as specified below .</i>		
Data Source	Responsible Party for	Frequency of data	Sampling

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Reports to State Medicaid Agency by PIHP	data collection/generation (check each that applies)	collection/generation: (check each that applies)	Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify: As issues requiring correction are identified.	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

Performance Measure:	DMA tracks waiver participation through reporting by the PIHP on new enrollees and consumers transferring in from other waivers.		
Data Source Reports from PIHP to State Medicaid Agency	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input type="checkbox"/> Other: Specify:	

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			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input checked="" type="checkbox"/> Other: Specify: The state will maintain running report to track unduplicated users during the waiver year.
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

Performance Measure:	DMA reviews the PIHP Innovations provider network for adequate capacity and choice as specified below.		
Data Source: PIHP produces network provider report showing subset of Innovations providers for State Medicaid Agency	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify: Interim reports may be required based on concerns about adequacy/choice	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis	Frequency of data aggregation and analysis:	Method of Aggregation Reporting:

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	(check each that applies)	(check each that applies)	(check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

Performance Measure:	DMA reviews the PIHP rate setting methodology for compliance with federal managed care regulations and the DMA-PIHP contract as specified below.		
Data Source: PIHP rate-setting policy	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify: Upon development and when changes to methodology are made	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Other: Specify: Upon development and when changes to methodology are made	

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Performance Measure:	<i>The PIHP reviews a sample of Innovations consumer records, including encounter data, to determine compliance with waiver assurances and reports to DMA as specified below.</i>		
Data Source: Report of record review findings by PIHP to State Medicaid Agency	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify: Semi-annually	
			<input checked="" type="checkbox"/> Other: Describe Random Sample of at least 10% of unduplicated Innovations participants during the waiver year
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Other: Specify: Semi-annually	

- a.ii If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Please note that the performance measures/monitoring activities outlined above regarding the authority of the State Medicaid Agency are meant to assure that all operational and administrative activities delegated to the PIHP as described in Appendix A-7 are carried out appropriately.

b. Methods for Remediation

- b.i Describe the States strategy for addressing individual problems as they are discovered.*

The PIHP will address and correct problems identified on a case by case basis in accordance with its contract with the Division of Medical Assistance (DMA). DMA may require a corrective action plan if the problems identified appear to require a change in the PIHP's processes for making accurate and timely decisions regarding level of care. DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team. The PIHP will notify the State immediately of any situation in which the health and safety of a consumer is jeopardized.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

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c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="checkbox"/>	Yes (complete remainder of item)
<input checked="" type="checkbox"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

N/A

Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

- a. **Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

SELECT ONE WAIVER TARGET GROUP	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	Aged or Disabled, or Both (<i>select one</i>)			
<input type="radio"/>	Aged or Disabled or Both – General (<i>check each that applies</i>)			
	<input type="checkbox"/> Aged (age 65 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Disabled (Physical) (under age 65)			
	<input type="checkbox"/> Disabled (Other) (under age 65)			
<input type="radio"/>	Specific Recognized Subgroups (<i>check each that applies</i>)			
	<input type="checkbox"/> Brain Injury			<input type="checkbox"/>
	<input type="checkbox"/> HIV/AIDS			<input type="checkbox"/>
	<input type="checkbox"/> Medically Fragile			<input type="checkbox"/>
	<input type="checkbox"/> Technology Dependent			<input type="checkbox"/>
<input checked="" type="radio"/>	Mental Retardation or Developmental Disability, or Both (<i>check each that applies</i>)			
	<input type="checkbox"/> Autism			<input type="checkbox"/>
	<input checked="" type="checkbox"/> Developmental Disability (includes Autism)	Birth		<input checked="" type="checkbox"/>
	<input checked="" type="checkbox"/> Mental Retardation	Birth		<input checked="" type="checkbox"/>
<input type="radio"/>	Mental Illness (<i>check each that applies</i>)			
	<input type="checkbox"/> Mental Illness (age 18 and older)			<input type="checkbox"/>
	<input type="checkbox"/> Serious Emotional Disturbance (under age 18)			

- b. **Additional Criteria.** The State further specifies its target group(s) as follows:

The Innovations waiver targets individuals who meet the ICF-MR eligibility criteria defined in The Division of Medical Assistance Clinical Coverage Policy No: 8E. The specific criteria can be found in Appendix B-6d of this application.

With the effective date of this renewal, new participants to this waiver will live with private families or in living arrangement where three or fewer persons unrelated to the proprietor live.

Appendix B-2: Individual Cost Limit

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*) Please note that a State may have only ONE individual cost limit for the purposes of determining eligibility for the waiver:

<input checked="" type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>			
<input type="radio"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>		
	The cost limit specified by the State is (<i>select one</i>):		
<input type="radio"/>	The following dollar amount: \$		
	The dollar amount (<i>select one</i>):		
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input type="radio"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
<input type="radio"/>	Other – <i>Specify</i> :		

- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

NA

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
	NA
<input type="checkbox"/>	Other safeguard(s) (<i>specify</i>):
	NA

Appendix B-3: Number of Individuals Served

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	585
Year 2	595
Year 3	600
Year 4 (renewal only)	605
Year 5 (renewal only)	610

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: *(select one)*:

<input checked="" type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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- c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.																									
<input checked="" type="radio"/>	<p>The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:</p> <p>Capacity is reserved for the following purposes:</p> <p>Transition of individuals from CAP-MR/DD (the MR/DD waiver control # 0429.04 serving the remainder of the state) to Innovations when participants move into one of the counties covered by the Innovations waiver which results in a change in the participant's Medicaid county of eligibility. The reserve figure is based on historical numbers of participants that have transitioned during the past three years and projected per capita growth.</p> <p>Reserved capacity for emergency needs. The reserve figure is based on historical numbers of participants that have had emergency needs during the past three years and projected per capita growth.</p> <p>The capacity that the State reserves in each waiver year is specified in the following table:</p> <table border="1" style="width: 100%; border-collapse: collapse; margin-top: 10px;"> <tr> <th colspan="3" style="text-align: center;">Table B-3-c</th></tr> <tr> <th rowspan="3" style="width: 35%; text-align: center;">Waiver Year</th><th style="width: 30%; text-align: center;">Purpose:</th><th style="width: 35%; text-align: center;">Purpose:</th></tr> <tr> <th style="text-align: center;">Reserved to accommodate transition between waivers- CAP-C and CAP-MR/DD</th><th style="text-align: center;">Reserved to accommodate crisis and emergencies</th></tr> <tr> <th style="text-align: center;">Capacity Reserved</th><th style="text-align: center;">Capacity Reserved</th></tr> <tr> <td style="text-align: center;">Year 1</td><td style="text-align: center;">10</td><td style="text-align: center;">2</td></tr> <tr> <td style="text-align: center;">Year 2</td><td style="text-align: center;">10</td><td style="text-align: center;">2</td></tr> <tr> <td style="text-align: center;">Year 3</td><td style="text-align: center;">5</td><td style="text-align: center;">2</td></tr> <tr> <td style="text-align: center;">Year 4 (renewal only)</td><td style="text-align: center;">5</td><td style="text-align: center;">2</td></tr> <tr> <td style="text-align: center;">Year 5 (renewal only)</td><td style="text-align: center;">5</td><td style="text-align: center;">2</td></tr> </table>	Table B-3-c			Waiver Year	Purpose:	Purpose:	Reserved to accommodate transition between waivers- CAP-C and CAP-MR/DD	Reserved to accommodate crisis and emergencies	Capacity Reserved	Capacity Reserved	Year 1	10	2	Year 2	10	2	Year 3	5	2	Year 4 (renewal only)	5	2	Year 5 (renewal only)	5	2
Table B-3-c																										
Waiver Year	Purpose:	Purpose:																								
	Reserved to accommodate transition between waivers- CAP-C and CAP-MR/DD	Reserved to accommodate crisis and emergencies																								
	Capacity Reserved	Capacity Reserved																								
Year 1	10	2																								
Year 2	10	2																								
Year 3	5	2																								
Year 4 (renewal only)	5	2																								
Year 5 (renewal only)	5	2																								

- d. Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	<p>Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:</p> <div style="border: 1px solid black; height: 40px; margin-top: 5px;"></div>

- f. Selection of Entrants to the Waiver.** Specify the policies that apply to the selection of individuals for entrance to the waiver:

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Individuals who seek services funded through the Innovations waiver are screened for their presumed eligibility. The screening process consists of a comprehensive review of clinical referral documents (medical and psychological information) and the completion of a support needs assessment to determine the intensity and scope of needed services. The PIHP uses the Supports Intensity Scale to assess support needs. As openings in the waiver become available, funding is offered to individuals with the greatest support needs based on the outcome of the Supports Intensity Scale. Assessments are updated prior to funding allocation to ensure that individuals with the greatest urgency of need receive funding first.

Based on the outcome of this assessment, individuals are ranked according to the following criteria:

Emergency

Individuals who present with emergency needs are offered entrance to the waiver ahead of other individuals to the extent that reserved capacity is available. A clinical team inclusive of at least one psychiatrist (child psychiatrist/adult psychiatrist) and a minimum of one developmental disability specialist assesses the emergency situation.

A person is considered to have emergency needs when :

- The individual is at significant, imminent risk of serious harm because the primary caregiver(s)/support system is/are not able to provide the level of support necessary to meet the person's basic needs;
And/or
- The individual requires protection from confirmed abuse, neglect, or exploitation;
And
- The Supports Intensity Scale shows needs that can be addressed through waiver services;
And
- The person is in need of at least one waiver service through the Innovations waiver;
And
- The person is able to be supported in a private home or a facility with three beds or less;
And
- There are no other service systems to meet the identified need.
Or
- The individual has identified support needs to support a child or family when that child has been determined by the County Department of Social Services to be at imminent risk of coming into custody of the agency;
And

The Supports Intensity Scale shows needs that can be addressed through waiver services.

Non-Emergency Referrals

Individuals who present with non-Emergency needs will be ranked according to the following criteria:

- The score obtained from the Supports Intensity Scale is ranked numerically across all referrals.
- Exceptional Medical or Exceptional Behavioral needs will add additional points to the overall ranking.
- In the event that persons are assessed to have the same intensity of need, the date of

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application will determine the ranking.

As openings in the waiver become available, funding is offered to individuals with the greatest support needs based on the outcome of the Supports Intensity Scale. To ensure that this information is current, assessments will be updated prior to funding allocation.

When reserved capacity is available, individuals who are transitioning from the CAP-MR-DD waiver receive priority consideration for these reserved slots. If reserved capacity is not available, individuals who are transitioning will be prioritized for entrance to the waiver based on the foregoing criteria.

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. a-1. **State Classification.** The State is a (*select one*):

<input checked="" type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input type="radio"/>	209(b) State

a-2. **Miller Trust State.**

<input type="radio"/>	Yes
<input checked="" type="radio"/>	No

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

<i>Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)</i>	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input checked="" type="checkbox"/>	SSI recipients
<input type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input checked="" type="checkbox"/>	Optional State supplement recipients
<input checked="" type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input checked="" type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
<input checked="" type="checkbox"/>	Medically needy in 1634 States and SSI Criteria States (42 CFR 435.320, 435.322 and 435.324)
<input checked="" type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :
	42 CFR 435.135 (pass-along)
	42 CFR 435.145 (foster care and adoption assistance)
<i>Special home and community-based waiver group under 42 CFR §435.217)</i> Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	

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<input checked="" type="radio"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.		
<input type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>		
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217		
<input type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):		
<input type="checkbox"/>	A special income level equal to (select one):		
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	of FBR, which is lower than 300% (42 CFR §435.236)	
<input type="radio"/>	\$	which is lower than 300%	
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
<input type="checkbox"/>	Medically needy without spend down in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)		
<input type="radio"/>	100% of FPL		
<input type="radio"/>	%	of FPL, which is lower than 100%	
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):
<input type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State and §1634) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State and §1634) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. <i>Complete Item B-5-c-1 (SSI State and §1634) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

- b-1. Regular Post-Eligibility Treatment of Income: SSI State and §1634 State.** The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>):		
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):		
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	of the FBR, which is less than 300%	
<input type="radio"/>	\$	which is less than 300%.	
<input type="radio"/>	%	of the Federal poverty level	
<input type="radio"/>	Other standard included under the State Plan (<i>specify</i>):		

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<input type="radio"/>	The following dollar amount:	<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (specify):	
ii. Allowance for the spouse only (select one):		
<input type="radio"/>	SSI standard	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (select one):		
<input type="radio"/>	AFDC need standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The following dollar amount:	<div style="border: 1px solid black; width: 100px; height: 20px; display: inline-block;"></div> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Other (specify):	
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:		
a. Health insurance premiums, deductibles and co-insurance charges		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	Not applicable (<i>see instructions</i>)	
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):	

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NOTE: Items B-5-b-2 and B-5-c-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State and §1634 state. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>			
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>		
	<input type="radio"/>	SSI standard	
	<input type="radio"/>	Optional State supplement standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i> :	
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>	%	of the FBR, which is less than 300%
	<input type="radio"/>	\$	which is less than 300%?
	<input type="radio"/>	%	of the Federal poverty level
	<input type="radio"/>	Other standard included under the State Plan (specify):	
<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.		
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>	Other (specify):		
ii. Allowance for the spouse only <i>(select one):</i>			
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
	<input type="radio"/>	SSI standard	
	<input type="radio"/>	Optional State supplement standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	\$	If this amount changes, this item will be revised.
	<input type="radio"/>	The amount is determined using the following formula:	
<input type="radio"/>	Not applicable <i>(see instructions)</i>		

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iii. Allowance for the family <i>(select one):</i>	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
<input type="radio"/>	Other <i>(specify)</i> : <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>
<input type="radio"/>	Not applicable <i>(see instructions)</i>
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable <i>(see instructions)</i>
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits <i>(specify)</i> : <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>		
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>	
<input type="radio"/>	The following standard under 42 CFR §435.121: <div style="border: 1px solid black; height: 20px; margin-top: 5px;"></div>	
<input type="radio"/>	Optional State supplement standard	
<input type="radio"/>	Medically needy income standard	
<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i>	
<input type="radio"/>	300%	of the SSI Federal Benefit Rate (FBR)
<input type="radio"/>	%	of the FBR, which is less than 300%
<input type="radio"/>	\$	which is less than 300% of the FBR

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	<input type="radio"/>	%	of the Federal poverty level
	<input type="radio"/>	Other (specify):	
	<input type="radio"/>	The following dollar amount: \$ If this amount changes, this item will be revised.	
	<input type="radio"/>	The following formula is used to determine the needs allowance:	
ii. Allowance for the spouse only (select one):			
	<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:	
Specify the amount of the allowance:			
	<input type="radio"/>	The following standard under 42 CFR §435.121:	
	<input type="radio"/>	Optional State supplement standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised.
	<input type="radio"/>	The amount is determined using the following formula:	
	<input type="radio"/>	Not applicable (<i>see instructions</i>)	
iii. Allowance for the family (select one)			
	<input type="radio"/>	AFDC need standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.	
	<input type="radio"/>	The amount is determined using the following formula:	
	<input type="radio"/>	Other (specify):	

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<input type="radio"/>	Not applicable (<i>see instructions</i>)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:	
a. Health insurance premiums, deductibles and co-insurance charges b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>):

d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance and a family allowance as specified in the State Medicaid Plan.. The State must also protect amounts for incurred expenses for medical or remedial care (as specified below).

i. Allowance for the personal needs of the waiver participant (<i>select one</i>):		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount:	\$ If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other (<i>specify</i>):	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. <i>Select one:</i>		
<input type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference:	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		

	a. Health insurance premiums, deductibles and co-insurance charges.
	b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>
<input type="radio"/>	Not applicable (<i>see instructions</i>)
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.

Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.		Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is (<i>insert number</i>):
	1	
ii.		Frequency of services. The State requires (<i>select one</i>):
	<input checked="" type="radio"/>	The provision of waiver services at least monthly
	<input type="radio"/>	Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed (*select one*):

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input checked="" type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity:</i>
	The PIHP performs evaluations and reevaluations of level of care under the terms of the risk contract between the Division of Medical Assistance and the PIHP.
<input type="radio"/>	Other (<i>specify</i>):

- c. **Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Persons performing initial evaluations of level of care for waiver participants are Psychologists, Psychological Associates or Physicians as appropriate based on the disability of the participant. All professionals must hold current licensure in the state of North Carolina.

- d. **Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The Innovations waiver targets individuals who meet the ICF-MR eligibility criteria defined in The Division of Medical Assistance Clinical Coverage Policy No: 8E. The Innovations waiver utilizes the following ICF-MR criteria to evaluate and reevaluate waiver eligibility:

The waiver participant requires active treatment necessitating the ICF-MR level of care. (Active treatment refers to aggressive, consistent implementation of a program of specialized and generic training, treatment and health services. Active treatment does not include service to maintain generally independent clients who are able to function with little supervision or in the absence of a continuous active treatment program.)

AND

Have a diagnosis of mental retardation, or a condition that is closely related to MR. Mental retardation is a disability characterized by significant limitations both in intellectual functioning and adaptive behavior as expressed in conceptual, practical and social skills. The condition originates before the age of 18. Persons with closely related conditions refers to individuals who have a severe chronic disability that meets ALL of the following conditions and is attributable to cerebral palsy or epilepsy or any other condition, other than mental illness, that is closely related to mental retardation because this condition results in impairment of general intellectual functioning or adaptive behavior similar to mentally retarded persons:

- 1. It is manifested before the person reaches age 22**
- 2. It is likely to continue indefinitely; and**
- 3. It results in substantial functional limitations in three or more of the following areas of major life activity:**
 - a. Self care (ability to take care of basic life needs for food, hygiene, and appearance)**
 - b. Understanding and use of language (ability to both understand others and to express ideas or information to others) and to express language (ability to both understand others and to express ideas or information to others either verbally or nonverbally)**
 - c. Learning (ability to acquire new behaviors, perceptions and information, and to apply experiences to new situations)**
 - d. Mobility (ambulatory, semi-ambulatory, non-ambulatory)**
 - e. Self-direction (managing one's social and personal life and ability to make decisions necessary to protect one's self)**
 - f. Capacity for independent living (age appropriate ability to live without extraordinary assistance)**

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The Piedmont Level of Care Assessment tool is used to determine the initial level of care for each waiver participant. Annual re-assessment of level of care is confirmed by the Support Coordinator.

- e. **Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. **Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Initial Level of Care Criteria:

A comprehensive evaluation is completed through the PIHP for all individuals who apply for Innovations waiver funding, including a Level of Care determination. Evaluations are completed by a Psychologist, Licensed Psychological Associate or Physician as appropriate based on the individual's specific clinical issue. The form used to document the initial level of care determination is called the Piedmont Level of Care Assessment. This is the same tool used to document ICF/MR admission.

If the presenting issue is mental retardation or a condition closely related to mental retardation, a Psychologist or Licensed Psychological Associate completes the evaluation. The evaluation includes intellectual testing and adaptive behavior assessment. The Piedmont Level of Care Assessment tool is used to document the outcome of this evaluation. To assure the accuracy and timeliness of Level of Care determination, the signature of the psychologist or psychological associate must be no more than 30 days old.

If the condition is cerebral palsy, epilepsy or a condition closely related to one of these two disabilities, a Physician completes the Level of Care determination. The evaluation will be a medical assessment. The Piedmont Level of Care Assessment tool is used to document the outcome of this evaluation. To assure the accuracy and timeliness of Level of Care determination, the signature of the physician must be no more than 30 days old. The PIHP completes the final determination of the authorization of Level of Care.

Re-evaluation of Level of Care:

Re-evaluation of Level of Care is completed annually during or up to 30 days prior to the birth month of the participant. Re-evaluations are completed by Qualified Professionals who are Support Coordinators (case managers) using the Piedmont Annual Recommendation for Level of Care, a component of the Individual Support Plan.

Annual assessments include the completion of an assessment of risks and support needs. The findings are addressed in the Individual Support Plan and recommendations.

The PIHP completes the final determination of the continued authorization of Level of Care. If the participant's condition or life circumstance has changed significantly during the past twelve months and continued eligibility is questionable, the participant is referred to the full evaluation process to verify continued eligibility.

- g. **Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input type="radio"/>	Every twelve months
<input checked="" type="radio"/>	Other schedule (<i>specify</i>):
	Reevaluations of the level of care take place at least annually for each waiver participant according to the following schedule: during or up to 30 days prior to the birth month of the waiver participant. If there is a change in the participant's condition, a re-evaluation is performed within 30-days of the identification of the change in condition.

- h. **Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

<input type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who perform initial evaluations.
<input checked="" type="radio"/>	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):
	Annual re-evaluations will be completed by the Qualified Professional (as defined in NC G.S. 122C). A Qualified Professional is equivalent to the federally defined Qualified Mental Retardation Professional.

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

The PIHP maintains a computerized tracking system of all level of care evaluations with their annual reevaluation due date. The data is reviewed monthly by the PIHP. The Support Coordinator (case manager) is notified if the evaluation is received outside the approved timeline.

- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

The initial level of care tool is maintained in written form. Copies are maintained in the participant's record by the PIHP case management unit as well as in the PIHP administrative files. Copies also are maintained by the local Department of Social Services, the agencies responsible for Medicaid eligibility. The annual re-evaluation document is maintained in written form by the PIHP case management unit and the administrative files of the PIHP.

B.6.b Quality Management: Level of Care.

8. Quality Management: Level of Care (LOC)

As a distinct component of the State's quality management strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

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a. Methods for Discovery: **Level of Care Assurance/Sub-assurances**

a.i.a An evaluation for LOC is provided to all applicants for whom there is reasonable indication that services may be needed in the future.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of Level of Care evaluations completed within 30 days of identification of need for services		
Data Source: PIHP UM data module.	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input checked="" type="checkbox"/> Other:	
		Semi-Annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		Semi-Annually	
Performance Measure:	Proportion of Level of Care evaluations that are reversed upon appeal		
Data Source PBH UM module Encounter Data	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		Semi annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		Semi Annually	

a.i.b The LOC of enrolled participants are reevaluated at least annually or as specified in the approved waiver.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of Level of Care evaluations completed at least annually for enrolled participants		
Data Source PIHP UM data module	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	

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		<i>Semi-Annually</i>	<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		<i>Semi Annually</i>	

a.i.c *The processes and instruments described in the approved waiver are applied to determine LOC.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of Level of Care evaluations completed using approved processes and instrument		
Data Source PIHP UM data module	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		<i>Semi-Annually</i>	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		Semi Annually	

b.ii Remediation Data Aggregation

If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation

b.i Describe the States strategy for addressing individual problems as they are discovered.

The PIHP will address and correct problems identified on a case by case basis and include the information in the report to DMA and the Intra-departmental Monitoring Team. DMA may require a corrective action plan if the problems identified appear to require a change in the PIHP's processes for making accurate and timely decisions regarding level of care. DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

N/A

Appendix B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
 - ii. given the choice of either institutional or home and community-based services.
- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

When funding is available prospective participants are informed of their feasible alternatives under the waiver and their option to choose waiver services as an alternative to institutional ICF-MR services by the PIHP. This decision is documented on the Individual Support Plan signature page. Annually, thereafter, the Freedom of Choice option is reviewed with the participant or the legally responsible person and the decision documented on the Individual Support Plan.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

The Freedom of Choice statement is maintained in written form as a component of the Individual Support Plan and is found in the record of the PIHP case management unit and the administrative files of the PIHP.

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Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

The PIHP makes available to participants with limited English proficiency and their legally responsible representatives materials that are translated into the prevalent non-English languages of the five-county area. The PHIP makes interpreter services available to individuals with limited English proficiency through a contract with a telephone language line and contracts with individual providers in the community for on-site interpretation.

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Appendix C: Participant Services

Appendix C-1: Summary of Services Covered

- a. Waiver Services Summary.** Appendix C-3 sets forth the specifications for each service that is offered under this waiver. *List the services that are furnished under the waiver in the following table. If case management is not a service under the waiver, complete items C-1-b and C-1-c:*

Statutory Services (check each that applies)		
Service	Included	Alternate Service Title (if any)
Case Management	<input type="checkbox"/>	
Homemaker	<input type="checkbox"/>	
Home Health Aide	<input type="checkbox"/>	
Personal Care	<input type="checkbox"/>	
Adult Day Health	<input type="checkbox"/>	
Habilitation	<input type="checkbox"/>	
Residential Habilitation	<input checked="" type="checkbox"/>	Residential Supports
Day Habilitation	<input checked="" type="checkbox"/>	Day Supports
Expanded Habilitation Services as provided in 42 CFR §440.180(c):		
Prevocational Services	<input type="checkbox"/>	
Supported Employment	<input checked="" type="checkbox"/>	
Education	<input type="checkbox"/>	
Respite	<input checked="" type="checkbox"/>	
Day Treatment	<input type="checkbox"/>	
Partial Hospitalization	<input type="checkbox"/>	
Psychosocial Rehabilitation	<input type="checkbox"/>	
Clinic Services	<input type="checkbox"/>	
Live-in Caregiver (42 CFR §441.303(f)(8))	<input type="checkbox"/>	
Other Services (select one)		
<input type="radio"/>	Not applicable	
<input checked="" type="radio"/>	As provided in 42 CFR §440.180(b)(9), the State requests the authority to provide the following additional services not specified in statute (<i>list each service by title</i>):	
a.	Assistive Technology Equipment and Supplies	
b.	Communication Devices	

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c.	Community Guide Services	
d.	Community Networking Services	
e.	Community Transition Services	
f.	Crisis Services	
g.	Home Supports	
h.	Home Modifications	
i.	Individual Goods and Services	
j.	Natural Supports Education	
j.	Specialized Consultation Services	
k.	Vehicle Modifications	
Extended State Plan Services (<i>select one</i>)		
<input checked="" type="radio"/> Not applicable		
<input type="radio"/> The following extended State plan services are provided (<i>list each extended State plan service by service title</i>):		
a.		
b.		
c.		
Supports for Participant Direction (<i>check each that applies</i>)		
<input checked="" type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E The waiver includes Information and Assistance in Support of Participant Direction, Financial Management Services or other supports for participant direction as waiver services.	
<input type="checkbox"/>	The waiver provides for participant direction of services as specified in Appendix E. Some or all of the supports for participant direction are provided as administrative activities and are described in Appendix E.	
<input type="radio"/>	Not applicable	
Support	Included	Alternate Service Title (if any)
Information and Assistance in Support of Participant Direction	<input checked="" type="checkbox"/>	Community Guide
Financial Management Services	<input checked="" type="checkbox"/>	Financial Supports Services
Other Supports for Participant Direction (<i>list each support by service title</i>):		
a.		
b.		
c.		

- b. Provision of Case Management Services to Waiver Participants.** Indicate how case management is furnished to waiver participants (*check each that applies*):

<input type="checkbox"/>	As a waiver service defined in Appendix C-3 (<i>do not complete C-1-c</i>)
<input type="checkbox"/>	As a Medicaid State plan service under §1915(i) of the Act (HCBS as a State Plan Option). <i>Complete item C-1-c.</i>
<input type="checkbox"/>	As a Medicaid State plan service under §1915(g)(1) of the Act (Targeted Case Management). <i>Complete item C-1-c.</i>
<input checked="" type="checkbox"/>	As an administrative activity. <i>Complete item C-1-c.</i>
<input type="checkbox"/>	Not applicable – Case management is not furnished as a distinct activity to waiver participants. <i>Do not complete Item C-1-c.</i>

- c. Delivery of Case Management Services.** Specify the entity or entities that conduct case management functions on behalf of waiver participants:

Under the 1915(b)/1915(c) concurrent waivers, the PIHP conducts all case management functions.

Appendix C-2: General Service Specifications

- a. **Criminal History and/or Background Investigations.** Specify the State's policies concerning the conduct of criminal history and/or background investigations of individuals who provide waiver services-(*select one*):

- ☒ **Yes.** Criminal history and/or background investigations are required. Specify: (a) the types of positions (e.g., personal assistants, attendants) for which such investigations must be conducted; (b) the scope of such investigations (e.g., state, national); and, (c) the process for ensuring that mandatory investigations have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid or the operating agency (if applicable):

As provided by NC G.S. 122C-80, criminal background checks must be conducted on all prospective employees of licensed MH/DD/SAS provider agencies who may have direct access to individuals served. PIHP licensed contract agencies must comply with this law. This includes direct care positions, administrative positions, and other support positions that have contact with individuals served. When prospective employees have lived in North Carolina for less than five consecutive years, a national criminal record check is obtained. When prospective employees have lived in the state for more than five years, only a state criminal record check is required.

As required by Innovations Service Provider Qualifications, unlicensed Provider Agencies who contract to provide Innovations services must also conduct criminal background checks on all prospective employees who may have direct access to individuals served. The PIHP conducts criminal background checks on Independent Practitioners.

When participants elect the Individual and Family Directed Services Option, criminal background checks must be obtained for any job applicant under serious consideration. Criminal background checks are provided without charge as a component part of Financial Supports Services in the Employer of Record Model. Criminal background checks must be performed in advance of payment to the employee for the performance of services on behalf of the Employer of Record. In the Agency with Choice Model the agency obtains a Criminal Background Check prior to hiring any employee referred for hire by a Managing Employer.

The PIHP reviews the provider agency (including Agencies with Choice) criminal record check policy at the time of initial credentialing of the agency and re-verifies agency credentials, including a sample of criminal background checks, at a frequency determined by the PIHP, no less than every three years. Annually, the PIHP reviews Employer of Record personnel practices to ensure that there is documentation of the criminal background check for each employee hired.

- ☐ **No.** Criminal history and/or background investigations are not required.

- b. **Abuse Registry Screening.** Specify whether the State requires the screening of individuals who provide waiver services through a State-maintained abuse registry (*select one*):

- ☒ **Yes.** The State maintains an abuse registry and requires the screening of individuals through this registry. Specify: (a) the entity (entities) responsible for maintaining the abuse registry; (b) the types of positions for which abuse registry screenings must be conducted; and, (c) the process for ensuring that mandatory screenings have been conducted. State laws, regulations and policies referenced in this description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

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As provided by NC G.S. 131E and NC G.S. 122C, the Department of Health and Human Services, Division of Health Service Regulation, maintains the Abuse Registry.

Licensed agencies who contract with the PIHP must conduct Abuse Registry Screenings of prospective employees for positions who have direct access to individuals receiving services. Information from both the Nurse Aide Registry and the Health Care Personnel Registry is available to the general public and all health care providers via the Internet through a 24-hour telephone voice response system.

As required by Innovations Service Provider Qualifications, unlicensed agencies that contract with the PIHP to provide Innovations Services are also required to conduct Abuse Registry screenings of prospective employees who provide waiver services to participants

When participants elect the Individual and Family Directed Services Option, Abuse Registry screenings must be conducted for any job applicant under serious consideration. Abuse Registry screenings are provided without charge as a component part of Financial Supports Services in the Employer of Record Model. Abuse Registry screenings must be performed in advance of payment to the employee for the performance of services on behalf of the Employer of Record. In the Agency with Choice Model, the Agency obtains an Abuse Registry Screening prior to hiring any employee referred for hire by a Managing Employer.

The PIHP reviews the provider agency (including Agencies with Choice) abuse registry screening policy at the time of initial credentialing and re-verifies agency credentials, including a sample of abuse registry screenings, at a frequency determined by the PIHP, no less than every three years. The PIHP reviews Employer of Record personnel practices annually to ensure that necessary screenings have been performed prior to employment.

☐ No. The State does not conduct abuse registry screening.

c. **Services in Facilities Subject to §1616(e) of the Social Security Act.** *Select one:*

- ☐ No. Home and community-based services under this waiver are not provided in facilities subject to §1616(e) of the Act. *Do not complete Items C-2-c.i – c.iii.*
- ☒ Yes. Home and community-based services are provided in facilities subject to §1616(e) of the Act. The standards that apply to each type of facility where waiver services are provided are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). *Complete Items C-2-c.i – c.iii.*

i. **Types of Facilities Subject to §1616(e).** Complete the following table for *each type* of facility subject to §1616(e) of the Act:

Type of Facility	Waiver Service(s) Provided in Facility	Facility Capacity Limit
Facilities for the Mentally Ill, the Developmentally Disabled and Substance Abusers including licensed	Residential Supports	Facility capacity for all newly developed facilities, effective April 1, 2008 is 3 beds or less. Participants that receive Residential

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<p>Alternative Family Living facilities (AFLs)</p>		<p>Supports at the time of this renewal may continue to receive services in facilities no larger than 8 beds.</p> <p>AFL Residential Support Providers are limited to 3 beds or less</p>
---	--	--

- i. **Larger Facilities:** In the case of residential facilities subject to §1616(e) that serve four or more individuals unrelated to the proprietor, describe how a home and community character is maintained in these settings.

New participants to this waiver may only live in residential facilities that serve three or fewer people who are unrelated to the proprietor. Participants currently living in facilities greater than three beds may choose to continue to receive services under this waiver. Participants who currently live in facilities larger than 4 beds will be offered the opportunity to transition to the B-3 option under the 1915(b) waiver.

Group homes with greater than three beds allow participants to live in residential neighborhoods in the community. Meals are served family style and residents access community activities, employment, schools or day programs. Per NC G.S.122C-51, it is the policy of the state to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care and freedom from mental and physical abuse, neglect and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment. Support Coordinators (administrative Case Managers) monitor monthly on-site in the group home to ensure that the participant is healthy and safe, and that the participant's needs are being met. Support Coordinators continue to offer participants choice of smaller facilities. Community Guides assist participants in transitioning to facilities of smaller size or homes of their own.

- iii. **Scope of Facility Standards.** By type of facility listed in Item C-2-c-i, specify whether the State's standards address the following (*check each that applies*):

Standard	Facility Type	Facility Type	Facility Type
	Facilities for the Mentally Ill, Developmentally Disabled and Substance Abusers.		
Admission policies	●	□	□

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Physical environment	●	<input type="checkbox"/>	<input type="checkbox"/>
Sanitation	●	<input type="checkbox"/>	<input type="checkbox"/>
Safety	●	<input type="checkbox"/>	<input type="checkbox"/>
Staff : resident ratios	●	<input type="checkbox"/>	<input type="checkbox"/>
Staff training and qualifications	●	<input type="checkbox"/>	<input type="checkbox"/>
Staff supervision	●	<input type="checkbox"/>	<input type="checkbox"/>
Resident rights	●	<input type="checkbox"/>	<input type="checkbox"/>
Medication administration	●	<input type="checkbox"/>	<input type="checkbox"/>
Use of restrictive interventions	●	<input type="checkbox"/>	<input type="checkbox"/>
Incident reporting	●	<input type="checkbox"/>	<input type="checkbox"/>
Provision of or arrangement for necessary health services	●	<input type="checkbox"/>	<input type="checkbox"/>

When facility standards do not address one or more of the topics listed, explain why the standard is not included or is not relevant to the facility type or population. Explain how the health and welfare of participants is assured in the standard area(s) not addressed:

- d. Provision of Personal Care or Similar Services by Legally Responsible Individuals.** A legally responsible individual is any person who has a duty under State law to care for another person and typically includes: (a) the parent (biological or adoptive) of a minor child or the guardian of a minor child who must provide care to the child or (b) a spouse of a waiver participant. Except at the option of the State and under extraordinary circumstances specified by the State, payment may not be made to a legally responsible individual for the provision of personal care or similar services that the legally responsible individual would ordinarily perform or be responsible to perform on behalf of a waiver participant. *Select one:*

<input checked="" type="radio"/>	No. The State does not make payment to legally responsible individuals for furnishing personal care or similar services.
<input type="radio"/>	Yes. The State makes payment to legally responsible individuals for furnishing personal care or similar services when they are qualified to provide the services. Specify: (a) the legally responsible individuals who may be paid to furnish such services and the services they may provide; (b) State policies that specify the circumstances when payment may be authorized for the provision of <i>extraordinary care</i> by a legally responsible individual and how the State ensures that the provision of services by a legally responsible individual is in the best interest of the participant; and, (c) the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 the personal care or similar services for which payment may be made to legally responsible individuals under the State policies specified here.</i>

- e. Other State Policies Concerning Payment for Waiver Services Furnished by Relatives/Legal Guardians.** Specify State policies concerning making payment to relatives/legal guardians for the provision of waiver services over and above the policies addressed in Item C-2-d. *Select one:*

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<input type="radio"/>	The State does not make payment to relatives/legal guardians for furnishing waiver services.
<input checked="" type="radio"/>	The State makes payment to relatives/legal guardians under <i>specific circumstances</i> and only when the relative/guardian is qualified to furnish services. Specify the specific circumstances under which payment is made, the types of relatives/legal guardians to whom payment may be made, and the services for which payment may be made. Specify the controls that are employed to ensure that payments are made only for services rendered. <i>Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.</i>

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The following relatives may provide services: legal guardians, parents of adult participants, and other relatives who live in the home of the participant. The waiver services that relatives or legal guardians may provide are Community Networking, Day Supports, Home Supports, and Residential Supports. Payments are made to relatives/legal guardians in the following circumstances:

- 1. The relative or legal guardian must meet the provider qualifications for the service.**
- 2. A qualified provider who is not a relative or legal guardian is (a) not available to provide the service or (b) is only willing to provide the service at an extraordinarily higher cost than the fee or charge negotiated with the qualified family member or legal guardian.**
- 3. The relative or legal guardian is not paid to provide any service that they would ordinarily perform in the household for an individual of similar age who does not have a disability.**
- 4. A relative and/or legal guardian who resides in the same household as the waiver participant and who exercises the Employer Authority (Employer of Record) on behalf of the participant in an Individual/Family Directed service arrangement may not furnish a service that is subject to the Employer Authority. The Managing Employer in an Agency with Choice model may not furnish a service that is subject to the Manager Employer's direction.**
- 5. Provider Agencies, Employers of Record, and Managing Employers (through the Agency with Choice) must submit documentation to the PIHP to demonstrate that the relative or legal guardian meets the qualifications to provide the service along with the justification for using the relative as the service provider rather than an unrelated provider. The PIHP must prior authorize the provision of services by the relative or legal guardian.**
- 6. Ordinarily, no more than 40 hours of service per week or seven daily units per week may be approved for service provision between all relatives who reside in the same household as the waiver participant. Additional service hours furnished by a relative or legal guardian who resides in the same household as the waiver participant may be authorized to the extent that another provider is not available or is necessary to assure the participant's health and welfare.**
- 7. When a relative or legal guardian is the service provider, provider agencies, Employers of Record, and/or the Managing Employers, as appropriate, monitor the relative's or legal guardian's provision of services on-site, at a minimum of one time per month.**
- 8. When a relative or legal guardian is the service provider, the PIHP Support Coordinator monitors the relative's provision of services on-site at a minimum of one time per month.**
- 9. Payments are only made for service authorized by the PIHP in the Individual Support Plan.**
- 10. For Innovations waiver services, the same monitoring procedures apply to parents and legal guardians as apply to provider agencies to ensure that payments are made only for services rendered.**
- 11. Biological or adoptive parents of a minor child, stepparents of a minor child, or the spouse of a waiver participant are not paid for the provision of waiver services.**

- Relatives/legal guardians may be paid for providing waiver services whenever the relative/legal guardian is qualified to provide services as specified in Appendix C-3. Specify any limitations on the types of relatives/legal guardians who may furnish services. Specify the controls that are employed to ensure that payments are made only for services rendered. *Also, specify in Appendix C-3 each waiver service for which payment may be made to relatives/legal guardians.*

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○	Other policy. <i>Specify:</i>

- f. **Open Enrollment of Providers.** Specify the processes that are employed to assure that all willing and qualified providers have the opportunity to enroll as waiver service providers as provided in 42 CFR §431.51:

Under its risk contract with DMA, the PIHP must establish policies and procedures to monitor the adequacy, accessibility and availability of its provider network to meet the needs of individuals served through the concurrent §1915(b)/ §1915(c) waivers. The PIHP must analyze its provider network and demonstrate an appropriate number, mix and geographic distribution of providers, including geographic access by beneficiaries to practitioners and facilities. The analysis is reviewed by DMA at the beginning of each contract period; at any time there has been a significant change in PIHP operations that may affect the adequacy of capacity and services, including changes in services, benefits, geographic service areas or payments or enrollment of a new population in the concurrent waivers; and annually thereafter during the annual site visits by the Intradepartmental Monitoring Team (IMT). Whenever network gaps are noted, the PIHP submits to DMA a network development strategy or plan to fill the gaps as well as periodically reports to DMA on the implementation plan or strategy.

Quality Management: Qualified Providers

As a distinct component of the State's quality management strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

- a. Methods for Discovery:

- a.i *The State verifies that providers, upon initial service delivery and on an ongoing basis, meet required licensure, certification and/or other standards prior to their furnishing waiver services.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of providers that meet licensure, certification, and/or other standards prior to their furnishing waiver services		
Data Source Provider performance monitoring	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify:	
		Semi-Annually	<input type="checkbox"/> Other: Describe

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Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other: Specify:	

Performance Measure:	Proportion of providers reviewed according to PIHP monitoring schedule to determine continuing compliance with licensing, certification, contract and waiver standards		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		Semi-Annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other: Specify:	

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Performance Measure:	Proportion of providers for whom problems have been discovered and appropriate remediation has taken place		
Data Source Provider performance monitoring to include plans of correction	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		Semi-Annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other: Specify:	

a.ii If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation

b.i Describe the States strategy for addressing individual problems as they are discovered.

The PIHP will address and correct problems identified on a case by case basis and include the

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information in the report to DMA and the Intra-departmental Monitoring Team. DMA may require a corrective action plan if the problems identified appear to require a change in the PIHP's processes for making accurate and timely decisions regarding level of care. DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team.

Any provider issues that affect the health and safety of waiver participants are reported to DMA immediately.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

1. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

N/A

Appendix C-3: Waiver Services Specifications

For each service listed in Appendix C-1, provide the information specified below. State laws, regulations and policies referenced in the specification are readily available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Service Specification			
Service Title:	Residential Supports		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Residential Supports consist of an integrated array of individually designed training activities, assistance and supervision. Residential Supports are provided in licensed/unlicensed community residential settings that include group homes, and Alternative Family Living homes.</p> <p>Residential Supports include:</p> <ol style="list-style-type: none"> (1) Habilitation Services aimed at assisting the participant to acquire, improve, and retain skills in self-help, general household management and meal preparation, personal finance management, socialization and other adaptive areas. Training outcomes focus on allowing the participant to improve his/her ability to reside as independently as possible in the community. (2) Assistance in activities of daily living when the participant is dependent on others to ensure health and safety. (3) Assistance, support, supervision and monitoring that allow the individual to participate in home life or community activities. Transportation to and from the residence and points of travel in the community is included. <p><u>Exclusions</u></p> <p>Transportation to/from a child's school is the responsibility of the school system rather than the Residential Supports Provider. Transportation to/from medical appointments is billed to State Plan Transportation rather than Residential Supports.</p> <p>Participants who receive Residential Supports may not receive Home Supports, Vehicle Modifications, Respite, Home Modifications or State Plan Personal Care Services. Payments for Residential Supports do not include payments for room and board, the cost of facility maintenance and upkeep.</p> <p>This service is not available at the same time of day as Community Networking, Day Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The amount of Residential Supports is subject to the individual budget as specified in Appendix C-4.			
Provider Specifications			
Provider	<input type="radio"/>	Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:

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Category(s) (check one or both):		Provider Agencies	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Facilities for the Mentally Ill, Developmentally Disabled and Substance Abusers - group homes.	NC G.S. 122 C	NC G.S. 122 C	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p> <p>Enrolled to provide Crisis Services or has an arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The Participant may select any enrolled Crisis Services provider in lieu of this provider however.</p>
Facilities for the Mentally Ill, Developmentally Disabled and	NC G.S.122C	NC G.S. 122 C	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p>

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Substance Abusers - Alternative Family Living Homes (AFL)			<p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p> <p>Enrolled to provide Crisis Services or has an arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The Participant may select any enrolled Crisis Services provider in lieu of this provider however.</p> <p>Site must be the primary residence of the AFL provider (includes couples and single persons) who receive reimbursement for cost of care.</p> <p>Back up staff must be employees of the agency.</p>
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Facilities for the Mentally Ill, Developmentally Disabled and Substance Abusers - include group homes.	<p>Group Homes</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the</p>

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		PIHP, no less than every three years
Facilities for the Mentally Ill, Developmentally Disabled and Substance Abusers - Alternative Family Living Homes (AFL)	Alternative Family Living Homes PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification			
Service Title:	Day Supports		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Day Supports provide assistance to the participant with acquisition, retention, or improvement in self-help, socialization and adaptive skills. Day Supports are furnished in a non-residential setting, separate from the home or facility where the participant resides. Day Supports focus on enabling the individual to attain or maintain his or her maximum functional level and are coordinated with any physical, occupational, or speech therapies listed in the Individual Support Plan. Transportation to/from the participant's home, the day supports facility and travel within the community is included. The cost of transportation to and from the day program is included in the payment rate.</p> <p>Participants may receive Day Supports outside the facility as long as the outcomes are consistent with the habilitation described in the Individual Support Plan and the service originates from the licensed day program. All licensure categories must be followed and the participant grouping must be appropriate to the age of the participant. This service may not duplicate services provided under Community Networking, Home Supports, Residential Supports and/or Supported Employment.</p> <p>This service shall not be furnished/billed at the same time of day as Community Networking, Home Supports, Residential Supports, Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The amount of Day Supports is subject to the limitation on the number of hours of services specified in Appendix C-4. The amount of Day Supports also is subject to the amount of the participant's individual budget as specified in Appendix C-4.			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:
			Provider Agencies
			Adult Day Health and Adult Day Care Programs
			Licensed Developmental Day Care Programs
			Before and After School Day Care Programs operated by NC Public School System
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="radio"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Provider Agencies	NC G.S. 122 C	NC G.S. 122 C	Approved as a provider in the PIHP provider network

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			<p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p>
Adult Day Health and Adult Day Care Programs		Certified by NC Division of Aging	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p>

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			High school diploma or high school equivalency and supervised by professional specified by Division of Aging Certification
Licensed Developmental Day Care Programs	NC G.S. 122 C	NC G.S.122C	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p>
Before and After School Day Care Programs Operated by NC Public School System			<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to participant</p>

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			<p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p>
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Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Provider Agencies	<p>Provider Agencies</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years</p>
Adult Day Health and Adult Day Care Programs	<p>Adult Day Health and Adult Day Care Programs</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years</p>
Developmental Day Care Programs	<p>Developmental Day Care Programs</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years</p>

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Before and After School Day Care Programs Operated by the NC Public School Programs	Before and After Day Care School Programs <p style="text-align: center;">PIHP</p>	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years		
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>	Provider managed

Service Specification	
Service Title:	Supported Employment
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Supported Employment Services provide assistance with choosing, acquiring, and maintaining a job for participants ages 16 and older for whom competitive employment has not been achieved and /or has been interrupted or intermittent.</p> <p>Supported employment services include:</p> <ol style="list-style-type: none"> 1. Pre-job training/education and development activities to prepare a person to engage in meaningful work-related activities which may include career/educational counseling, job shadowing, assistance in the use of educational resources, training in resume preparation, job interview skills, study skills, assistance in learning skills necessary for job retention; 2. Employment in a group such as an enclave or a mobile crew; 3. Assisting a participant to develop and operate a micro-enterprise. This assistance consists of: (a) aiding the participant to identify potential business opportunities; (b) assistance in the development of a business plan, including potential sources of business financing and other assistance including potential sources of business financing and other assistance in developing and launching a business; (c) identification of the supports that are necessary in order for the participant to operate the business; and (d) ongoing assistance, counseling and guidance once the business has been launched; 4. Coaching and employment support activities that enable a participant to complete job training or maintain employment such as monitoring, supervision, assistance in job tasks, work adjustment training, and counseling; 5. Transportation between work or between activities related to employment. Other forms of transportation must be attempted first; and/or 6. Employer consultation with the objective of identifying work related needs of the participant and proactively engaging in supportive activities to address the problem or need. <p>Documentation will be maintained in the file of each provider agency or Employer of Record specifying that this service is not otherwise available under a program funded under section 110 of the Rehabilitation Act of 1973, or Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.) for this participant.</p> <p><u>Exclusions</u></p> <p>FFP is not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:</p> <ol style="list-style-type: none"> 1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program; 2. Payments that are passed through to users of supported employment programs; or 3. Payments for training that are not directly related to a participant's supported employment program. <p>This service is not available at the same time of day as Community Networking, Day Supports, Home</p>	

Supports, Residential Supports, Respite or one of the State Plan Medicaid services that works directly with the person.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The amount of Supported Employment Services is subject to the limitation on the number of hours of services specified in Appendix C-4. The amount of Supported Employment Services also is subject to the amount of participant's individual budget as specified in Appendix C-4.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/>	Participant. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:
	Employee in a self directed arrangement		Provider Agencies
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="radio"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Employee in a self directed arrangement		NC G.S.122C, as applicable	Staff that work with participants are approved by Employer of Record OR recommended by Managing Employer and approved by Agency with Choice At least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan High school diploma or equivalency and three years of experience and supervised by the Employer of Record or Managing Employer (persons who do not have three years of experience and were employed at the implementation of this waiver may continue to provide Supported Employment Services to the same participant) Clinical oversight by a qualified professional or associate professional

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			<p>under the supervision of a qualified professional in the field of developmental disabilities by Agency with Choice, if electing Agency with Choice model</p> <p>For services directed by an Employer of Record, State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director. Agencies with Choice follow State Nursing Board Regulations</p> <p>Competencies as specified by the PIHP</p>
Provider Agencies		NC G.S.122C	<p>Approved as a vendor in the PIHP provider network</p> <p>Agency staff that work with participants: Are at least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping If providing transportation, have a valid North Carolina driver's license and a safe driving record and has an acceptable level of automobile liability insurance. Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry. Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan High school diploma or high school equivalency with three years of experience (persons who do not have three years of experience and were employed at the implementation of this waiver may continue to provide Supported Employment Services to the same participant) and supervised by an associate/qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities Competencies as specified by the PIHP</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	

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Employee in a self directed arrangement	Employer of Record or Agency with Choice		Prior to hire	
	PIHP		Employer of Record Annually Agency with Choice as specified for provider agencies	
Provider Agencies	Provider Agencies		Verifies employee qualifications at the time employee is hired	
	PIHP		Upon initial reviews PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years	
Service Delivery Method				
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="radio"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/>	Provider managed

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Service Specification			
Service Title:	Respite		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Respite services provide periodic support and relief to the primary caregiver(s) from the responsibility and stress of caring for the individual. This service enables the primary caregiver to meet or participate in planned or emergency events, and to have planned time for him/her and/or family members. Respite may include in and out-of-home services, inclusive of overnight, weekend care, emergency care (family emergency based, not to include out of home crisis) or continuous care up to ten consecutive (10) days. The primary caregiver is the person principally responsible for the care and supervision of the individual and must maintain his/her primary residence at the same address as the individual.</p> <p><u>Exclusions</u> This service may not be used as a daily service in individual support. This service is <u>not</u> available to individuals who receive Residential Supports and/or those who live in licensed residential settings or Alternative Family Living Homes. Staff sleep time is not reimbursable. Respite services are only provided for the individual; other family members, such as siblings of the individual, may not receive care from the provider while Respite Care is being provided/billed for the individual. Respite Care is not provided by any individual who resides in the individual's primary place of residence. FFP will not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved by the State that is not a private residence.</p> <p>This service is not available at the same time of day as Community Networking, Day Supports, Home Supports, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The cost of 24 hours of respite care cannot exceed the per diem rate for the average community ICF-MR Facility. The amount of Respite Services is subject to the amount of participant's individual budget as specified in Appendix C-4			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/>	Individual. List types:	<input checked="" type="radio"/>
		Individual Selected by the Participant	Provider Agencies
			Provider Agencies who operate private respite homes
			Nursing Respite, Provider Agencies
			Nursing Respite, Home Care Agencies
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="radio"/> Relative/Legal Guardian

Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Employee in a self directed arrangement		NC G.S.122C , as applicable	<p>Approved by Employer of Record OR recommended by Managing Employer and approved by Agency with Choice</p> <p>At least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>Supervised by the Employer of Record or Managing Employer</p> <p>Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities by Agency with Choice, if electing Agency with Choice model</p> <p>If providing Nursing Respite, must be a Licensed RN or Licensed LPN in North Carolina</p> <p>For services directed by an Employer of Record, State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director Agencies with Choice follow State Nursing Board Regulations</p>
Provider Agencies, facility based and in-home services	NC G.S.122C	NC G.S. 122-C	<p>Credentialed as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English,</p>

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			<p>understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized need of the participants as described in the Individual Support Plan</p> <p>Supervised by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities</p> <p>Licensed RN or Licensed LPN in North Carolina</p>
<p>Provider Agencies who operate private respite homes</p>	<p>Private home respite services serving individuals outside their private home are subject to licensure under NC G.S. 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.</p>	<p>NC G.S. 122-C</p>	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized need of the participants as described in the Individual Support Plan</p> <p>Supervised by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities</p>
<p>Nursing Respite, Provider Agencies</p>		<p>NC G.S. 122-C</p>	<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p>

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			<p>Has RN or LPN license</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license and a safe driving record and has an acceptable level of automobile liability insurance.</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry.</p> <p>Qualified in CPR and First Aid and the customized need of the participants as described in the Individual Support Plan</p>
Home Care Agencies	<p>Licensed by the NC DHHS, Division of Health Services Regulation in accordance with NCGS 131E, Article 6, Part C</p>		<p>NC G.S. 122C, as applicable</p> <p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Has RN or LPN license</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized need of the participants as described in the Individual Support Plan</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Employee in a self directed arrangement	<p>Employer of Record or Agency with Choice</p> <p>PIHP</p>		<p>Prior to hire</p> <p>Employer of Record Annually</p> <p>Agency with Choice as specified</p>

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		for provider agencies	
Provider Agencies	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years	
Provider Agencies who operate private respite homes	Provider Agencies, Private Respite Homes PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years	
Nursing Respite, Provider Agencies	Nursing Respite Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years	
Home Care Agencies	Home Care Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="radio"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/> Provider managed

Service Specification	
Service Title:	Assistive Technology Equipment and Supplies
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Assistive Technology Equipment and Supplies are necessary for the proper functioning of items and systems, whether acquired commercially, modified, or customized, that are used to increase, maintain, or improve functional capabilities of participants. This service covers purchases, leasing, shipping costs, and as necessary, repair of equipment required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. All items must meet applicable standards of manufacture, design, and installation. The Individual Support Plan clearly indicates a plan for training the participant, the natural support system and paid caregivers on the use of the requested equipment and supplies. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant.</p> <p>Assistive Technology: Equipment and Supplies covers the following:</p> <p><u>I. Aids For Daily Living</u></p> <ol style="list-style-type: none"> (1) Adaptive equipment to enable a participant to feed him/herself (e.g. utensils, gripping aid for utensils, adjustable universal utensil cuff, utensil holder, scooper, trays, cups, bowls, plates, plate guards, non-skid pads for plates/bowls, wheelchair cup holders, and glasses that are specifically designed to allow a participant to feed him/herself.) (2) Adaptive hygiene and dressing aids (3) Adaptive switches and attachments (4) Adaptive toileting and bath chairs (5) Adaptive toothbrushes (6) Assistive devices for participants with hearing and vision loss (e.g. assistive listening devices; TDD, large visual display devices, Braille screen communicators, FM Systems, volume control large print telephones, and tele touch systems) (7) Dietary scales (8) Food/fluid thickeners for dysphasia treatment (9) Positioning chairs, and beds (10) Non-disposable clothing protectors (11) Non-disposable incontinence items with disposable liners for use by participants ages three and above (12) Nutritional Supplements recommended by a physician that are taken by mouth rather than by tube and which are not covered by Medicaid State plan as a Home Infusion Therapy benefit (13) Special Clothing to meet the unique needs of the participant with a disability (14) Toilet trainer with anterior and lateral supports (15) Universal holder accessories for dressing, grooming and hygiene <p><u>II. Gross Motor Development</u></p>	

(1) Adaptive Tricycles for gross motor development

III. Environmental Control

- (1) Specialized Global Positioning Devices when recommended by a licensed psychologist or licensed psychological associate and accompanied by a behavior support plan that describes how paid or natural supports will supervise the participant who is using the recommended device.**
- (2) Computer equipment, adaptive peripherals and adaptive workstation to accommodate access from bed to power mobility device when it allows the participant control of his or her environment reduces paid supports, assists in gaining independence, or when it can be demonstrated that it is necessary to protect the health and safety of the participant.**
- (3) Software is approved only when required to operate accessories included for environmental control or to support the participant in planning and budgeting.**

Computers will not be authorized to improve socialization or educational skills, provide recreation or diversion activities, or to be used by any other person other than the participant.

IV. Positioning Systems

- (1) Stenders with trays and attachments**
- (2) Prone boards with attachments**
- (3) Positioning chairs and sitters for participants that do not use a wheelchair for mobility**
- (4) Multi-function physio system, bolster balls, and wedges**
- (5) Motor activity shapes**
- (6) Therapeutic balls**
- (7) Visualizer balls**
- (8) Physio roll therapy mats when used with adaptive positioning devices**

V. Alert Systems

Alert systems are limited to participants who live alone or who are alone for significant parts of the day and have no regular caregiver for extended periods of time and who would otherwise require extensive routine supervision. This service may also be used by participants who live in private homes if the use of the equipment results in a fading or reduction of paid services. Equipment purchase and monthly monitoring charges are covered for the following :

- (1) Personal Emergency Response Systems (PERS)**
- (2) Alarm systems/alert systems, including auditory, vibratory, heat sensing and visual to ensure the health and safety of the participant, as well as signaling devices for participants with hearing and visual loss**
- (3) Telephone Line Restoration Systems when participant fails to hang the phone up during suspected health and safety issues**
- (4) In Activity Motion Detectors**
- (5) Lockboxes to enable emergency responders to enter the participant's home without damage to windows or doors**
- (6) Medical alarms that offer live two-way voice communication without handheld devices (such as telephones), including remotely located speakers and microphones.**
- (7) Medical alarms that connect participants directly to family members or friends who are willing and able to respond to emergency requests from the participant. The participant's Individual Support Plan identifies the natural support system who have agreed to respond to emergency requests from the participant.**
- (8) Medication Reminder Systems and/or Monitored Automatic Pill Dispensers**

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(9) Pre-paid, pre-programmed, cellular phones that allow a participant who is participating in employment or community activities without paid or natural supports and who may need assistance due to an accident, injury, or inability to find the way home. The participant's Individual Support Plan outlines a protocol that is followed if the participant has an urgent need to request help while in the community. Cellular phones are not for convenience or general purpose use and costs associated with non-emergency use are excluded.

(10) Supervised Photoelectric Smoke Detectors

VI Repair of Equipment

(1) Repair of Equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant must own any equipment that is repaired.

(2) Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

Exclusions

(1) Items that are not of direct or remedial benefit to the participant are excluded from this service.

(2) Computer desks and other furniture items are not covered.

(3) Service and maintenance contracts and extended warranties; and equipment or supplies purchased for exclusive use at the school/home school are not covered.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The service is limited to expenditures of \$15,000 over the duration of the Waiver. This limit does not include nutritional supplements and monthly alert monitoring system charges.

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="radio"/>	Individual. List types:	<input checked="" type="radio"/>	Agency. List the types of agencies:
		Specialized Vendor Suppliers		Alert Response Centers
				Durable Medical Equipment Providers
				Home Care Agencies
				Commercial/Retail Businesses

Specify whether the service may be provided by (check each that applies):

☐

Legally Responsible Person

☐

Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing
Alert Response Centers	Applicable state/local business license		Response Centers must be staffed by trained individuals, 24 hours/day, 365 days/year Meets applicable state and local requirements and regulations for type of

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			device that the vendor is providing
Durable Medical Equipment Providers	Applicable state/local business license	DMA enrolled vendor	Meets applicable state and local requirements and regulations for type of device that the vendor is providing
Home Care Agencies	Licensed by the NC DHHS, Division of Health Services Regulation, in accordance with NCGS 131E, Article 6, Part C	DMA enrolled vendor	Meets applicable state and local requirements and regulations for type of device that the vendor is providing
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements and regulations for type of device that the business is providing
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Specialized Vendors	PIHP	Prior to first use	
Alert Response Centers	PIHP	Prior to first use	
Durable Medical Equipment Providers	PIHP	Prior to first use	
Home Care Agencies	PIHP	Prior to first use	
Commercial/Retail Businesses	PIHP	Prior to first use	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/> Provider managed

Service Specification	
Service Title:	Communication Devices
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Communication Devices are necessary when normal speech is non-functional and/or when physical impairments make a gestural system impossible and/or ineffective. An aided system requires access to a symbolic system that is separate from the body. Selection of devices (and training outcomes for those devices) must be specific to the participant and based on age, cognitive ability, fine and gross motor ability, environmental need and presence or absence of sensory impairment. These devices assist in making the participant as independent as possible in the community. A written recommendation by a Speech/Language Pathologist, licensed to practice in North Carolina, must be obtained to ensure that the communication device to be selected will meet the unique needs of the participant. The Individual Support Plan specifies who will train and how the participant will be trained to effectively use the device for functional communication purposes and who in, his/her natural support system and paid caregivers, will be trained on the use of equipment, who will provide that training and how the equipment will be used to support the goals of the Individual Support Plan.</p> <p>Communication Devices covered include:</p> <ol style="list-style-type: none"> (1) Low Technology and Clinician-Made Devices (2) High Technology and commercially available devices and systems dedicated to the purpose of assisted augmentative communication (3) Standard Computers, Computer Driven Devices, Monitors, and Operating Peripherals, and printers adapted for use of the participant for communication purposes, when there is documentation that a computer will meet the needs of the participant more appropriately than a dedicated augmentative communication device. (4) Computer software specifically designed to support functional communication (5) Mounting Kits and accessories (6) Switch/Pointers/Access Equipment, all types standard and specialized (7) Keyboard/Emulators/Key Guards (8) Voice Synthesizers (9) Carry Cases (10) Supplies (battery, battery charger) (11) Artificial Larynges <p>This service includes purchases, leasing, and as necessary, repair of equipment required to enable participants to increase, maintain or improve their functional communication abilities. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant must own any equipment that is repaired.</p> <p><u>Exclusions</u></p> <p>(1) Items that are not of direct or remedial benefit to the participant are excluded from this service. Waiver funding will not be used to replace equipment that has not been reasonably cared for and</p>	

maintained.			
(2) Cameras except when the camera is an integral component of the augmentative communication device; service and maintenance contracts; extended warranties; and equipment or supplies purchased for exclusive use at the school/home school are not covered. Replacement printer cartridges and batteries may be provided only to the extent that the items are needed for use by the participant to meet his/her communication needs.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The service is limited to expenditures of \$15,000 over the duration of the Waiver.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/> Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:	
	Specialized Vendor Suppliers	Commercial/Retail Businesses	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements for type of device that the business is providing
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:	Frequency of Verification	
Specialized Vendors	PIHP	Prior to first use	
Commercial/Retail Businesses	PIHP	Prior to first use	
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="radio"/> Provider managed	

Service Specification	
Service Title:	Community Guide
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input checked="" type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Community Guide Services assist participants in locating and coordinating community resources and activities. These services also support participants, representatives, employers and managing employers who direct their own waiver services by providing direct assistance in their participant direction responsibilities. Community Guide Services are intermittent and fade as community connections develop and skills increase in participant direction. Community Guides assist and support (rather than direct and manage) the participant throughout the service delivery process.</p> <p>Specific functions are:</p> <ol style="list-style-type: none"> (1) Informing and coordinating community resources including coordination among primary, preventative, and chronic care providers (2) Assistance in locating and accessing non-Medicaid community supports and resources that are related to achieving Individual Support Plan (ISP) goals (3) Assistance in locating options for renting or purchasing a personal residence, assisting with purchasing furnishings for the personal residence (4) Instruction and counseling which guides the participant in problem solving and decision making (5) Advocacy on behalf of the participant (6) Supporting the person in preparing, participating in and implementing the Individual Support Plan (7) Providing training on the Individual and Family Directed Supports Option, if the participant is considering directing services and supports (8) Guidance with management of the individual budget (9) Coordinating of services with the Financial Supports Services provider, if the participant is self-directing services under the Employer of Record Model, including guidance on use of the individual and family directed budget (self-directed budget) (10) Providing information on recruiting, hiring, managing, training, evaluating, and changing support staff, if the participant is self-directing services (11) Assisting with the development of schedules and outlining staff duties, if the participant is self-directing services (12) Assisting with understanding staff qualifications and record keeping requirements, if the participant is self-directing services (13) Providing on-going information to assure that participants and their families/representatives understand the responsibilities involved with self-direction, including reporting on expenditures and other relevant information and training (14) Coordinating services with the Agency with Choice if the participant is directing services under the Agency with Choice Model <p>This service does not duplicate administrative case management services. Administrative case management services (support coordination) includes assisting the participant in the development of the ISP, completing or gathering evaluations inclusive of the re-evaluation of the level of care, monitoring the implementation of the ISP, choosing service providers, coordination of benefits and monitoring the health and safety of the participant.</p>	

Exclusions			
The provider of Community Guide Services may only additionally provide Community Transition, Individual Goods and Services and Financial Support services to the waiver participant.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The amount of Community Guide Services is subject to the amount of the participant's individual budget as specified in Appendix C-4.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/> Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:	
	Employee in a self directed arrangement	Provider Agencies	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative and Legal Guardian	
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Employee in a self directed arrangement			NC G.S. 122C as applicable Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice At least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background checks present no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan High school diploma or equivalency and supervised by the Employer of Record or Managing Employer Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities employed by Agency with Choice, if electing Agency with Choice model Meets Community Guide Competencies

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			as specified by the PIHP
Provider agencies			<p>NC G.S. 122C, as applicable</p> <p>Credentialed as a provider in the PIHP network Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background checks present no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p> <p>Meets Community Guide competencies specified by the PIHP.</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Employee in a self directed arrangement	<p>Employer of Record or Agency with Choice</p> <p>PIHP</p>	<p>Prior to hiring</p> <p>Employer of Record Annually</p> <p>Agency with Choice as specified for provider agencies</p>
Provider Agencies	<p>Provider Agency</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency</p>

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		determined by the PIHP, no less than every three years	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="radio"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/> Provider managed

Service Specification	
Service Title:	Community Networking
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input checked="" type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Community Networking services provide individualized day activities that support the participant's definition of a meaningful day in an integrated community setting, with persons who are not disabled. This service is provided separate and apart from the participant's private residence, other residential living arrangement, and/or the home of a service provider. These services do not take place in licensed facilities and are intended to offer the participant the opportunity to develop meaningful community relationships with non disabled individuals. Services are designed to promote maximum participation in community life while developing natural supports within integrated settings. Community Networking services enable the participant to increase or maintain their capacity for independence and develop social roles valued by non-disabled members of the community.</p> <p><u>Community Networking services consist of:</u></p> <ul style="list-style-type: none"> (1) Participation in adult education; (2) Development of community based time management skills; (3) Community based classes for the development of hobbies or leisure/cultural interests; (4) Volunteer work; (5) Participation in formal/informal associations and/or community groups; (6) Training and education in self-determination and self-advocacy; (7) Using public transportation; (8) Inclusion in a broad range of community settings that allow the participant to make community connections; and/or (9) For children, this service includes staffing supports to assist children to participate in day care/ after school summer programs that serve typically developing children and are not funded by Day Supports. <p>This service includes a combination of training, personal assistance and supports as needed by the participant during activities. Transportation to/from the participant's residence and the training site(s) is included. Payment for attendance at classes and conferences is also included.</p> <p><u>Exclusions</u></p> <p>This does not include the cost of hotels, meals, materials or transportation while attending conferences. This service does not include activities that would normally be a component of a participant's home/residential life or services. This service does not pay day care fees or fees for other childcare related activities. The service may not duplicate services provided under Community Guide, Day Supports, Home Supports, Residential Supports, and/or Supported Employment services.</p> <p>This service may not be furnished/claimed at the same time of day as Day Supports, Home Supports, Residential Supports, Respite, Supported Employment or one of the state plan Medicaid services that works directly with the participant.</p>	

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Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Payment for attendance at classes and conferences will not exceed \$1000/year. The amount of Community Networking services is subject to the limitation on the number of hours of services specified in Appendix C-4. The amount of Community Networking services is subject to the amount of the participant's individual budget as specified in Appendix C-4.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/> Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:	
	Employee in a self directed arrangement	Provider Agency	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="radio"/>	
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Employee in a self directed arrangement			NC G.S.122C as applicable Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice At least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan High school diploma or equivalency and supervised by the Employer of Record or Managing Employer Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities by Agency with Choice, if electing Agency with Choice model For services directed by an Employer of Record, State Nursing Board Regulations must be followed for tasks that present

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			health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director. Agencies with Choice follow State Nursing Board Regulations
Provider Agencies			<p>NC G.S. 122C, as applicable</p> <p>Credentialed as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background checks present no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Employee in a self directed arrangement	<p>Employer of Record or Agency with Choice</p> <p>PIHP</p>	<p>Prior to hiring</p> <p>Employer of Record Annually</p> <p>Agency with Choice as specified for provider agencies</p>
Provider Agencies	<p>Provider Agencies</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review</p> <p>PIHP re-verifies agency</p>

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		credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years	
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>
		Provider managed	

Service Specification			
Service Title:	Community Transition		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Community Transition is one-time, set-up expenses for adult participants to facilitate their transition from a Developmental Center (institution), community ICF-MR Group Home, nursing facility or another licensed living arrangement (group home, foster home, or alternative family living arrangement) to a living arrangement where the participant is directly responsible for his or her own living expenses. This service may be provided only in a private home or apartment with a lease in the participant's/legal guardian's/representative's name or a home owned by the participant.</p> <p><u>Covered transition services are:</u></p> <ul style="list-style-type: none"> (1) Security deposits that are required to obtain a lease on an apartment or home; (2) Essential furnishings, including furniture, window coverings, food preparation items, bed/bath linens; (3) Moving expenses required to occupy and use a community domicile; (4) Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water; and/or (5) Service necessary for the individual's health and safety such as pest eradication and one-time cleaning prior to occupancy. <p>Community Transition expenses are furnished only to the extent that the participant is unable to meet such expense or when the support cannot be obtained from other sources. These supports may be provided only once to a wavier participant. These services are available only during the three-month period that commences one month in advance of the participant's move to an integrated living arrangement.</p> <p><u>Exclusions</u></p> <p>Community Transition does not include monthly rental or mortgage expense; regular utility charges; and/or household appliances or diversional/recreational items such as televisions, VCR players and components and DVD players and components. Service and maintenance contracts and extended warranties are not covered. Community Transition services can be accessed only one time from Either the 1915b or 1915c waiver.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The cost of Community Transition is a life time limit of \$5000.00 per participant.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/>	Individual. List types:	<input checked="" type="radio"/>
		Specialized Vendor Suppliers	Agency. List the types of agencies:
			Agencies that provide Community Guide and Financial Support Services
			Commercial/Retail Businesses
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian

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Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Specialized Vendor Suppliers			Meets applicable state and local regulations for type of service that the provider/supplier is providing as approved by PIHP
Agencies that provide Community Guide Services			NC G.S. 122C, as applicable Credentialed as a provider in the PIHP provider network Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable regulations for type of service that the provider/supplier is providing as approved by PIHP
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Specialized Vendor Suppliers	PIHP		At the time of first use
Agencies that provide Community Guide Services	PIHP		Upon initial credentialing PIHP re-verifies agency credentials, at a frequency determined by the PIHP, no less than every three years
Commercial/Retail Businesses	PIHP		At the time of first use
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Crisis Services
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input checked="" type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Crisis Services is a tiered approach to support waiver participants when crisis situations occur that present a threat to the participant's health and safety or the health and safety of others. These behaviors may result in the participant losing his or her home, job, or access to activities and community involvement. Crisis Services is an immediate intervention available 24 hours per day, 7 days per week to support the person who is primarily responsible for the care of the participant. Crisis Services is provided as an alternative to institutional placement or psychiatric hospitalization. Service authorization can be accessed by telephone or planned through the Individual Support Plan (ISP) to meet the needs of the participant. Following service authorization, any needed modifications to the Individual Support Plan and Individual Budget will occur within 5 working days of the date of verbal service authorization.</p> <p><u>Primary Crisis Response</u></p> <p>Trained staff are available to provide "first response", crisis services to waiver participants they support, in the event of a crisis. These activities include:</p> <ol style="list-style-type: none"> (1) Assess the nature of the crisis to determine whether the situation can be stabilized in the current location, or if a higher-level intervention is needed; (2) Determine and contact agencies needed to secure higher level intervention or out of home services; (3) Provide direction to staff present at the crisis or provide direct intervention to de-escalate behavior or protect others living with the participant during behavioral episodes; (4) Contact the Support Coordinator following the intervention to arrange Crisis Behavioral Consultation for the participant; and/or (5) Provide direction to service providers who may be supporting the participant in day programming and community settings, including direct intervention to de-escalate behavior or protect others during behavioral episodes (enhanced staffing to provide one additional staff person in settings where the participant may be receiving other services). <p><u>Crisis Behavioral Consultation</u></p> <p>Crisis Behavioral Consultation is available to participants that have significant, intensive, challenging behaviors that have resulted in a crisis situation requiring the development of a Crisis Support plan. These activities include:</p> <ol style="list-style-type: none"> (1) Development or refinement of interventions to address behaviors or issues that precipitated the behavioral crisis and/or (2) Training and technical assistance to the Primary Responder and others who support the participant on crisis interventions and strategies to mitigate issues that resulted in the crisis. 	

Out of Home Crisis

Out of Home Crisis is a short-term service for a participant experiencing a crisis and requiring a period of structured support and or/programming. The service takes place in a licensed facility or licensed private home respite setting, separate and apart from the participant's living arrangement. Services are provided by staff trained in meeting the needs of a participant who is experiencing a crisis.

Crisis Services will be authorized in 14 to 30 calendar day increments, typically not to exceed 90 calendar days. In situations requiring Crisis Services in excess of 90 calendar days, the PIHP Medical Director or Assistant Medical Director must approve such authorization based on review of a transition plan that details the transition of the participant from crisis supports to other appropriate services.

Exclusions

This service may not be provided during the same authorization period as Specialized Consultative Services.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

Provider Specifications

Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input type="checkbox"/>	Agency. List the types of agencies:
			Provider Agencies	
			Provider Agencies who operate licensed facilities or private respite homes	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>	Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Provider Agencies			NC G.S. 122C, as applicable Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant

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			<p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>Qualified professional in the field of developmental disabilities</p> <p>Meets Crisis Services Competencies specified by the PIHP</p>
<p>Provider Agencies who operate licensed facilities or private respite homes</p>	<p>NC G.S. 122C</p> <p>Private home respite services serving individuals outside their private home are subject to licensure under NC G.S. 122C Article 2 when: more than two individuals are served concurrently, or either one or two children, two adults, or any combination thereof are served for a cumulative period of time exceeding 240 hours per calendar month.</p>		<p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>Qualified professional in the field of developmental disabilities</p> <p>Meets Crisis Services Competencies specified by the PIHP</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
<p>Provider Agencies</p>	<p>Provider Agencies</p> <p>PIHP</p>	<p>Verifies employee qualifications at the time employee is hired</p> <p>Upon initial review</p> <p>PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three</p>

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		years
Provider Agencies who operate licensed facilities or private respite homes	Provider Agencies PIHP	Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years
Service Delivery Method		
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/> Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Home Modifications
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Home Modifications are physical modifications to a private residence that are necessary to ensure the health, welfare, and safety of the participant or to enhance the participant's level of independence. A private residence is a home owned by the participant or his/her family (natural, adoptive, or foster family). Items that are portable may be purchased for use by a participant who lives in a residence rented by the participant or his/her family. This service covers purchases, installation, maintenance, and as necessary, the repair of home modifications required to enable participants to increase, maintain or improve their functional capacity to perform daily life tasks that would not be possible otherwise. A written recommendation by an appropriate professional is obtained to ensure that the equipment will meet the needs of the participant.</p> <p>Items that are not of direct or remedial benefit to the participant are excluded from this service. Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment. The waiver participant or his/her family must own any equipment that is repaired.</p> <p><u>Covered Modifications are:</u></p> <ul style="list-style-type: none"> (1) Ramps and Portable Ramps (2) Grab Bars (3) Handrails (4) Lifts, elevators, manual, or other electronic lifts, including portable lifts or lift systems that are used inside a participant's home (5) Porch stair lifts (6) Modifications and/or additions to bathroom facilities <ul style="list-style-type: none"> a) Roll in shower b) Sink modifications c) Bathtub modifications/grab bars d) Toilet modifications e) Water faucet controls f) Floor urinal and bidet adaptations g) Plumbing modifications (7) Widening of doorways/hallways, turnaround space modifications for improved access and ease of mobility, excluding locks (8) Specialized accessibility/safety adaptations/additions <ul style="list-style-type: none"> a) Electrical wiring b) Fire/safety adaptations c) Shatterproof windows d) Floor coverings for ease of ambulation e) Modifications to meet egress regulations f) Automatic door openers/doorbells 	

- g) Voice activated, light activated, motor activated electronic devices to control the participants home environment
- h) Medically necessary portable heating and/or cooling adaptation to be limited to one unit per participant
- i) Stationary built in therapeutic tables

Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation (e.g., in order to improve entrance/egress to a residence or to configure a bathroom to accommodate a wheelchair).

Exclusions

Participants who receive Residential Supports may not receive this service.

Central air conditioning; plumbing; swimming pools; service and maintenance contracts and extended warranties are not covered.

Equipment or supplies purchased for exclusive use at the school/home school are not covered.

Waiver funding will not be used to replace equipment that has not been reasonably cared for and maintained.

Specify applicable (if any) limits on the amount, frequency, or duration of this service:

The service is limited to expenditures of \$20,000 over the duration of the Waiver.

Provider Specifications

Provider Category(s) (check one or both):	<input checked="" type="radio"/> Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:
	Specialized Vendor Suppliers	Commercial/Retail Businesses
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian

Provider Qualifications (provide the following information for each type of provider):

Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Specialized Vendors	Applicable state/local business license		All services are provided in accordance with applicable State or local building codes and other regulations. All items must meet applicable standards of manufacture, design, and installation.
Commercial/Retail Businesses	Applicable state/local business license		All services are provided in accordance with applicable State or local building codes and other regulations. All items must meet applicable standards of manufacture, design, and installation.

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Specialized Vendors	PIHP	Prior to first use
Commercial/Retail	PIHP	Prior to first use

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Businesses			
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/> Provider managed

Service Specification	
Service Title:	Home Supports
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Home Supports are habilitation and support services which provide training and assistance to enable the participant to acquire and maintain skills, which allow more independence. Home Supports augment the family and natural supports of the participant and consist of an array of services that are required to maintain and assist the participant to live in community settings. Home Supports consist of:</p> <ul style="list-style-type: none"> (1) Training and or support in interpersonal skills and the development and maintenance of personal relationships; (2) Assistance and training in activities of daily living such as bathing, dressing, grooming, eating, toileting, transferring, and other similar task; (3) Supporting the participant in living in his/her community such as shopping, recreation, personal banking, grocery shopping and other community activities; (4) Assistance with therapeutic exercises, supervision of self administration of medication and other services essential to health care at home including transferring, ambulation and use of special mobility devices; (5) Assistance with monitoring health status and physical condition; (6) Supervision of the person in the absence of the natural supports; and/or (7) Transportation related to the implementation of activities provided under Home Supports. <p>Intensive night support is available to support participants in their private home, when the participant needs extensive supervision and support. Habilitation, support and/or supervision are provided to assist with positioning, high medical needs, elopement, and/or behaviors that would result in injury to self or other people. Staff implements interventions and assistance as defined in the Individual Support Plan. The Individual Support Plan includes an assessment and if indicated a fading plan or plan for obtaining assistive technology to reduce the amount of intensive night support needed by the participant. Intensive night support requires prior authorization by the PIHP and approval by the Medical Director or Assistant Medical Director and must be reviewed every six months.</p> <p>These services are provided in the participant's private home. Participants may receive Home Supports outside the private home as long as the outcomes are consistent with the habilitation described in the Individual Support Plan and the service originates from the private home. These services are not provided in the home or office of a staff person or agency.</p> <p><u>Exclusions</u></p> <p>This service is not provided to participants who receive Residential Supports. This service may not be furnished/billed at the same time of day as Day Supports, Community Networking, Residential Supports, Respite, Supported Employment or one of the State Plan Medicaid services that works directly with the person.</p>	

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Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The amount of Home Supports is subject to the limitation on the number of hours of services specified in Appendix C-4. The amount of Home Supports also is subject to the amount of participant's individual budget as specified in Appendix C-4.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/>	Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:
	Employee in a self directed arrangement		Provider agencies
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="radio"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Employee in a self directed arrangement			NC G.S. 122C, as applicable Approved by Employer of Record or recommended by Managing Employer and approved by Agency with Choice At least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan High school diploma or equivalency and supervised by the Employer of Record or Managing Employer Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities by Agency with Choice, if electing Agency with Choice model For services directed by an Employer of Record, State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant

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			<p>as directed by the PIHP Medical Director or Assistant Medical Director. Agencies with Choice follow State Nursing Board Regulations.</p> <p>Employer of Record maintains an agreement with a Crisis Services Provider to respond to participant crisis situations.</p> <p>Agency with Choice provides or maintains an agreement with a Crisis Service Provider to respond to participant crisis situations. The Participant, however, may select any enrolled Crisis Services provider in lieu of this provider.</p>
Provider Agencies			<p>NC G.S. 122C, as applicable</p> <p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license and a safe driving record and has an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or high school equivalency and supervised by a associate/qualified professional in the field of developmental disabilities OR associate professional under the supervision of a qualified professional in the field of developmental disabilities OR a qualified professional in the field of developmental disabilities</p> <p>Enrolled to provide Crisis Services or arrangement with an enrolled Crisis Services Provider to respond to participant crisis situations. The Participant, however, may select any</p>

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			enrolled Crisis Services provider in lieu of this provider.	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Employee in a self directed arrangement	Employer of Record Agency with Choice PIHP		Prior to hiring Employer of Record Annually Agency with Choice as specified for provider agencies	
Provider Agencies	Provider Agencies PIHP		Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input checked="" type="radio"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/>	Provider managed

Service Specification			
Service Title:	Individual Goods and Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input checked="" type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Individual Goods and Services are services, equipment or supplies not otherwise provided through this waiver or through the Medicaid State Plan that address an identified need in the Individual Support Plan (including improving and maintaining the individual's opportunities for full membership in the community) and meet the following requirements:</p> <p>(1) the item or service would decrease the need for other Medicaid services; AND/OR (2) promote inclusion in the community; AND/OR (3) increase the person's safety in the home environment; AND (4) the individual does not have the funds to purchase the item or service.</p> <p>Exclusions</p> <p>Individual Goods and Services do not include experimental goods and services inclusive of items which may be defined as restrictive under NC G.S. 122C-60. This service is available only to individuals who self direct at least one of their services.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
<p>The cost of individual directed goods and services for each individual cannot exceed \$2,000.00 annually. The amount of Individual Goods and Services is also subject to the amount of the participant's individual budget as specified in Appendix C-4.</p>			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/>	Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:
		Employee in a self directed arrangement	Commercial/Retail Businesses
			Financial Support Services Agency
			Agency with Choice
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input checked="" type="radio"/> Relative only in self-directed option and if the relative does not reside in the participant's home
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)

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Employee in a self-directed arrangement			<p>NC G.S.122C, as applicable</p> <p>Staff that work with participants are approved by Employer of Record OR recommended by Managing Employer and approved by Agency with Choice</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>If providing transportation, have a valid North Carolina driver's license, a safe driving record and an acceptable level of automobile liability insurance</p> <p>Criminal background check present no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Qualified in CPR and First Aid and the customized needs of the participant as described in the Individual Support Plan</p> <p>High school diploma or equivalency and supervised by the Employer of Record or Managing Employer</p> <p>Clinical oversight by a qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities by Agency with Choice, if electing Agency with Choice model</p> <p>For services directed by an Employer of Record, State Nursing Board Regulations must be followed for tasks that present health and safety risks to the participant as directed by the PIHP Medical Director or Assistant Medical Director. Agencies with Choice follow State Nursing Board Regulations.</p>
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements for type of item that the vendor is providing
Agency with Choice			<p>Agency enrolled with PBH</p> <p>NC G.S.122C, as applicable</p> <p>Meets applicable state and local requirements for type of item that the vendor is providing</p>

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Financial Support Services Agency			Agency enrolled with PBH NC G.S.122C, as applicable Meets applicable state and local requirements for type of item that the vendor is providing	
Verification of Provider Qualifications				
Provider Type:	Entity Responsible for Verification:		Frequency of Verification	
Self Employed Individual (self-directed only)	Employer of Record or Agency with Choice PIHP		Prior to hiring Employer of Record Annually Agency with Choice as specified for a provider agency	
Commercial/Retail Businesses	PIHP		Prior to first use	
Financial Supports Agency	PIHP		Annually	
Agency with Choice	PIHP		Annually	
Service Delivery Method				
Service Delivery Method (check each that applies):	<input checked="" type="radio"/>	Participant-directed as specified in Appendix E	<input type="checkbox"/>	Provider managed

Service Specification			
Service Title:	Natural Supports Education		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Natural Supports Education provides training to families and the participant's natural support network in order to enhance the decision making capacity of the natural support network, provide orientation regarding the nature and impact of the intellectual and other developmental disabilities upon the participant, provide education and training on intervention/strategies, and provide education and training in the use of specialized equipment and supplies. The requested education and training must have outcomes directly related to the needs of the participant or the natural support network's ability to provide care and support to the participant. In addition to individualized natural support education, reimbursement will be made for enrollment fees and materials related to attendance at conferences and classes by the primary caregiver. The expected outcome of this training is to develop and support greater access to the community by the participant by strengthening his or her natural support network.</p> <p><u>Exclusions</u></p> <p>The cost of transportation, lodging, and meals are not included in this service. Natural Supports Education excludes training furnished to family members through Specialized Consultation Services. Training and education, including reimbursement for conferences, are excluded for family members and natural support networks when those members are employed to provide supervision and care to the participant.</p>			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Reimbursement for conference and class attendance will be limited to \$1,000 per year.			
Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/> Individual. List types:	<input checked="" type="radio"/> Agency. List the types of agencies:	
	Employee in a self directed arrangement	Provider Agencies enrolled in the PIHP Network	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian	
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Employee in a self directed arrangement			NC G.S. 122C, as applicable Approved by Employer of Record OR recommended by Managing Employer and approved by Agency with Choice Are at least 18 years old Able to effectively read, write, and communicate verbally in English,

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			<p>understand instructions and perform record keeping</p> <p>The Criminal Background Check presents no risk to the participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry.</p> <p>Has expertise as appropriate in the field in which the training is provided as identified in the Individual Support Plan</p> <p>Qualified professional or associate professional under the supervision of a qualified professional in the field of developmental disabilities.</p> <p>Qualified in the customized needs of the participant as described in the Individual Support Plan</p>
Provider Agencies			<p>NC G.S.122C, as applicable</p> <p>Approved as a provider in the PIHP provider network</p> <p>Agency staff that work with participants:</p> <p>Are at least 18 years old</p> <p>Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping</p> <p>Criminal background check presents no health and safety risk to participant</p> <p>Not listed in the North Carolina Health Care Abuse Registry.</p> <p>Qualified professional or Associate professional under the supervision of a qualified professional in the field of developmental disabilities</p> <p>Qualified in the customized needs of the participants as described in the Individual Support Plan</p>

Verification of Provider Qualifications

Provider Type:	Entity Responsible for Verification:	Frequency of Verification
Employee in a self directed arrangement	<p>Employer of Record or Agency with Choice</p> <p>PIHP</p>	<p>Prior to hiring</p> <p>Employer of Record Annually</p> <p>Agency with Choice as specified for Provider Agencies</p>
Provider Agencies	Provider Agencies	Verifies employee qualifications at the time employee is hired

State:	Piedmont North Carolina
Effective Date	April 1, 2008

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		PIHP	Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="checkbox"/>
			Provider managed

Service Specification	
Service Title:	Specialized Consultation
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Specialized Consultative Services provide expertise, training and technical assistance in a specialty area (psychology, behavior intervention, speech therapy, therapeutic recreation, augmentative communication, assistive technology equipment, occupational therapy or nutrition) to assist family members, support staff and other natural supports in assisting participants with developmental disabilities who have long term intervention needs. Under this model, family members and other paid/unpaid caregivers are trained by a certified, licensed, and/or registered professional, or qualified assistive technology professional to carry out therapeutic interventions, consistent with the Individual Support Plan, therefore increasing the effectiveness of the specialized therapy. This service will also be utilized to allow specialists defined to be an integral part of the Individual Support Team to participate in team meetings and provide additional intensive consultation and support for individuals whose medical and/or behavioral /psychiatric needs are considered to be extreme or complex. The participant may or may not be present during service provision. The professional and support staff are able to bill for their service time concurrently.</p>	
Activities covered are:	
<ol style="list-style-type: none"> (1) Observing the participant to determine needs; (2) Assessing any current interventions for effectiveness; (3) Developing a written intervention plan; (4) Intervention plan will clearly delineate the interventions, activities and expected outcomes to be carried out by family members, support staff and natural supports; (5) Training of relevant persons to implement the specific interventions/support techniques delineated in the intervention plan and to observe, record data and monitor implementation of therapeutic interventions/support strategies; (6) Reviewing documentation and evaluating the activities conducted by relevant persons as delineated in the intervention plan with revision of that plan as needed to assure progress toward achievement of outcomes; (7) Training and technical assistance to relevant persons to instruct them on the implementation of the participant's intervention plan; (8) Participating in team meetings; and/or (9) Tele Consultation through use of two-way, real time-interactive audio and video between places of lesser and greater clinical expertise to provide behavioral and psychological care when distance separates the care from the participant. 	
Exclusions	
Specialized Consultative Services excludes services provided through Natural Supports Education and Crisis Services.	
Specify applicable (if any) limits on the amount, frequency, or duration of this service:	

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Provider Specifications			
Provider Category(s) (check one or both):	<input checked="" type="radio"/> Individual. List types: <input checked="" type="radio"/> Agency. List the types of agencies:		
	Independent Practitioners	Provider Agencies	
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/> Legally Responsible Person	<input checked="" type="radio"/>	
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)
Independent Practitioner	Licensure specific to discipline, if applicable	Certification or registration specific to discipline, if applicable	NC G.S.122C, as applicable Approved by the PIHP At least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping Criminal background check presents no health and safety risk to participant Not listed in the North Carolina Health Care Abuse Registry Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology and nutrition; state certification for recreational therapy; Board Certified Behavior Analyst-MA; Master's degree and expertise in Augmentative Communication; State Certification in Assistive Technology Qualified in the customized need of the participants as described in the Individual Support Plan
Provider Agencies			NC G.S.122C, as appropriate Approved as a provider in the PIHP provider network Agency staff that work with participants: Are at least 18 years old Able to effectively read, write, and communicate verbally in English, understand instructions and perform record keeping Criminal background check presents no health and safety risk to participant

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			<p>Not listed in the North Carolina Health Care Abuse Registry</p> <p>Staff must hold appropriate NC license for physical therapy, occupational therapy, speech therapy, psychology and nutrition; state certification for recreational therapy; Board Certified Behavior Analyst-MA; Master's degree and expertise in Augmentative Communication; State Certification in Assistive Technology</p> <p>Qualified in the customized needs of the participant as described in the Individual Support Plan</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Independent Practitioners	PIHP		At time of initial review and annually thereafter
Provider Agencies	Provider Agencies PIHP		Verifies employee qualifications at the time employee is hired Upon initial review PIHP re-verifies agency credentials, including a sample of employee qualifications, at a frequency determined by the PIHP, no less than every three years
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input checked="" type="radio"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/> Provider managed

Service Specification	
Service Title:	Vehicle Modifications
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>	
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.
<input type="radio"/>	Service is not included in the approved waiver.
Service Definition (Scope):	
<p>Vehicle Modifications are devices, service or controls that enable participants to increase their independence or physical safety by enabling their safe transport in and around the community. The installation, repair, maintenance, and training in the care and use of these items are included. The waiver participant or his/her family must own or lease the vehicle. The vehicle must be covered under an automobile insurance policy that provides coverage sufficient to replace the adaptation in the event of an accident. Modifications do not include the cost of the vehicle or lease itself. There must be a written recommendation by an appropriate professional that the modification will meet the needs of the participant. All items must meet applicable standards of manufacture, design, and installation. Installation must be performed by the adaptive equipment manufacturer's authorized dealer according to the manufacturer's installation instructions, National Mobility Equipment Dealer's Association, Society of Automotive Engineers, National Highway and/or Traffic Safety Administration guidelines.</p> <p>Repair of equipment is covered for items purchased through the waiver or purchased prior to waiver participation, as long as the item is identified within this service definition and the cost of the repair does not exceed the cost of purchasing a replacement piece of equipment.</p> <p><u>Covered Modifications are:</u></p> <ol style="list-style-type: none"> (1) Door handle replacements (2) Door modifications (3) Installation of raised roof or related alterations to existing raised roof system to approve head clearance (4) Lifting devices (5) Devices for securing wheelchairs or scooters (6) Adapted steering, acceleration, signaling, and breaking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training in the installed device is provided by certified personnel (7) Handrails and grab bars (8) Seating modifications (9) Lowering of the floor of the vehicle (10) Safety/security modification <p><u>Exclusions</u></p> <ol style="list-style-type: none"> (1) Vehicle Modifications are not available to participant's who receive Residential Supports or who live in licensed residential facilities. (2) The cost of renting/leasing a vehicle with adaptations; service and maintenance contracts and extended warranties; and adaptations purchased for exclusive use at the school/home school are not covered. (3) Items that are not of direct or remedial benefit to the participant are excluded from this service. 	

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Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
The service is limited to expenditures of \$20,000 over the duration of the Waiver.			
Provider Specifications			
Provider Category(s) <i>(check one or both):</i>	<input checked="" type="radio"/>	Individual. List types:	<input checked="" type="radio"/>
		Specialized Vendors Individuals	Commercial/Retail Businesses
Specify whether the service may be provided by <i>(check each that applies):</i>	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/>
			Relative/Legal Guardian
Provider Qualifications <i>(provide the following information for each type of provider):</i>			
Provider Type:	License <i>(specify)</i>	Certificate <i>(specify)</i>	Other Standard <i>(specify)</i>
Specialized Vendors	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing
Commercial/Retail Businesses	Applicable state/local business license		Meets applicable state and local requirements for type of device that the vendor is providing
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Specialized Vendors	PIHP		Prior to first use
Commercial/Retail Businesses	PIHP		Prior to first use
Service Delivery Method			
Service Delivery Method <i>(check each that applies):</i>	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/>
			Provider managed

Service Specification			
Service Title:	Financial Support Services		
<i>Complete this part for a renewal application or a new waiver that replaces an existing waiver. Select one:</i>			
<input type="radio"/>	Service is included in approved waiver. There is no change in service specifications.		
<input checked="" type="radio"/>	Service is included in approved waiver. The service specifications have been modified.		
<input type="radio"/>	Service is not included in the approved waiver.		
Service Definition (Scope):			
<p>Financial Support Services is the umbrella service for the continuum of supports offered to Innovations Waiver participants who elect the Individual and Family Directed Services Option, Employer of Record Model. Financial Support Services are provided to assure that funds for self-directed services are managed and distributed as intended. The service also facilitates employment of support staff by the Employer.</p> <ol style="list-style-type: none"> (1) Filing claims for self-directed services and supports; (2) Payment of payroll to employees hired to provide services and supports; (3) Deducting all required federal, state, and local taxes, including unemployment fees, prior to issuing paychecks to employees; (4) Ordering employment related supplies and paying invoices for other expenses such as training of employees; (5) Administering benefits for employees hired to provide services and supports; (6) Maintaining ledger accounts for each participant's funds; (7) Producing expenditure reports that are required, including reports to the participant/employer/family, concerning expenditures of funds against their budgets; (8) Requesting criminal background checks, driver's license checks, and health care registry checks of providers of self-directed services; (9) Tracking and monitoring individual budget expenditures; (10) Facilitating Workers Compensation Application on behalf of the Employer of Record; and/or (11) Serving as the Internal Revenue approved Fiscal Employer Agent. 			
Exclusions			
The provider of Financial Support Services may only additionally provide Community Guide Services, Community Transition Services, and Individual Goods and Services under the Innovations Waiver.			
Specify applicable (if any) limits on the amount, frequency, or duration of this service:			
Provider Specifications			
Provider Category(s) (check one or both):	<input type="checkbox"/>	Individual. List types:	<input checked="" type="checkbox"/> Agency. List the types of agencies:
			Provider Agencies
Specify whether the service may be provided by (check each that applies):	<input type="checkbox"/>	Legally Responsible Person	<input type="checkbox"/> Relative/Legal Guardian
Provider Qualifications (provide the following information for each type of provider):			
Provider Type:	License (specify)	Certificate (specify)	Other Standard (specify)

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Provider Agencies	Applicable state/local business license		<p>NC G.S. 122C, as applicable</p> <p>Approved as a provider in the PIHP provider network</p> <p>Approved by the Internal Revenue Service to be an employer agent in accordance with Section 3504 of the IRS Code and IRS Revenue Procedure 70-6, Bonded</p> <p>Meets all IRS requirements and be certified by the IRS as an employer agent</p> <p>Understands the laws and rules that regulate the expenditure of public funds</p> <p>Able to utilize accounting systems that operate effectively on a large scale as well as track individual budgets</p> <p>Able to develop, implement, and maintain an effective payroll system that adheres to all related tax obligations, both payment and reporting</p> <p>Able to conduct criminal and other required background checks</p> <p>Able to generate service management and statistical information and reports during each payroll cycle</p> <p>Have at least two years of basic accounting and payroll experience</p>
Verification of Provider Qualifications			
Provider Type:	Entity Responsible for Verification:		Frequency of Verification
Provider Agency	PIHP		Upon initial approval and annually thereafter
Service Delivery Method			
Service Delivery Method (check each that applies):	<input type="checkbox"/>	Participant-directed as specified in Appendix E	<input checked="" type="radio"/> Provider managed

Appendix C-4: Additional Limits on Amount of Waiver Services

Additional Limits on Amount of Waiver Services. Indicate whether the waiver employs any of the following additional limits on the amount of waiver services (*check each that applies*).

State:	Piedmont North Carolina
Effective Date	April 1, 2008

When a limit is employed, specify: (a) the waiver services to which the limit applies; (b) the basis of the limit, including its basis in historical expenditure/utilization patterns and, as applicable, the processes and methodologies that are used to determine the amount of the limit to which a participant's services are subject; (c) how the limit will be adjusted over the course of the waiver period; (d) provisions for adjusting or making exceptions to the limit based on participant health and welfare needs or other factors specified by the state; (e) the safeguards that are in effect when the amount of the limit is insufficient to meet a participant's needs; and, (f) how participants are notified of the amount of the limit.

■	<p>Limit(s) on Set(s) of Services. There is a limit on the maximum dollar amount of waiver services that is authorized for one or more sets of services offered under the waiver. <i>Furnish the information specified above.</i></p>
	<p>The following limits apply:</p> <ul style="list-style-type: none"> (1) Adult participants who receive Residential Supports: No more than 40 hours per week is authorized for any combination of Community Networking, Day Supports, and/or Supported Employment Services. (2) Child participants who receive Residential Supports: During the school year, no more than 20 hours per week is authorized for any combination of Community Networking, Day Supports, and/or Supported Employment Services. When school is not in session, up to 40 hours per week may be authorized. (3) Adult participants who live in private homes: No more than 84 hours per week is authorized for any combination of Community Networking, Day Supports, Supported Employment and/or Home Supports. (4) Child participants who live in private homes: During the school year, no more than 54 hours per week is authorized for any combination of Community Networking, Day Supports, Supported Employment, and/or Home Supports. When school is not in session, up to 84 hours per week may be authorized. (5) Adult and child participants who live in private homes with intensive support needs: These participants may receive up to an additional 12 hours per day intensive night support, a component of Home Supports, to allow for 24 hours per day of support with the prior approval of the Medical Director or Assistant Medical Director.
■	<p>Prospective Individual Budget Amount. There is a limit on the maximum dollar amount of waiver services authorized for each specific participant. <i>Furnish the information specified above.</i></p>

All waiver participants are assigned an individual budget as a component of their Individual Support Plan (ISP). The individual budget will represent the total cost of waiver services authorized in the Individual Support Plan. Participants who live in private homes can self-direct a portion of their individual budget or they may choose to self-direct the entire individual budget, with the exception of Financial Support Services. Participants who live in residential programs may choose to self-direct some of the services they receive. The individual budget will contain both agency and individual and family directed services, depending on the needs and preferences of the participant. The base budget methodology is uniform for all participants in the waiver. Budget methodology is open to public review. Budgets are reviewed as changes are made to the ISP; review occurs no less frequently than one time annually. Budgets are monitored for under- and over-expenditures through the use of service utilization data. If under- or over-expenditures are identified, the Support Coordinator will work with the participant/representative to complete a budget modification if needed.

The Support Coordinator (Case Manager), as part of the Individual Support Plan development, will explain the methodology for budget development, total dollar value of the budget and mechanisms available to the participant/representative to modify their individual budget.

Participants that are new to the waiver will have an assigned initial individual budget. A cost matrix is used for assigning a “base” cost for each budget. The base is reflective of the cost to fund services for persons currently enrolled in the waiver who are of similar age and life circumstances. Life circumstances are reflective of age ranges: 0-3, 4-15, 16-22, 23-35, 36-65, and 66-over and current life stages: Home, School-Home, School-Residential, Employment-Home, Employment-Residential. The cost matrix will be updated annually to ensure that it accurately reflects the average cost of services to participants in each life stage.

Modification to Individual Budgets

All modifications to the individual budget must be based on a revision/update to the Individual Support Plan and be authorized. A modification to the individual budget may be requested through the Support Coordinator when the participant has a newly identified need or change in life circumstance that would require additional services that cannot be funded within the current individual budget amount. Modifications to the individual budget may only be authorized to address service needs related to the individual’s health and well being. If a modification to the Individual Budget is authorized during the participant’s current plan year, the modification will be prorated for the remainder of the year. If the modification is authorized at the beginning of a new ISP year, the budget will be effective with the new ISP start date.

Life Transitions are one type of change that could constitute a need for a modification to the individual budget. Participants who experience a life transition that requires additional funding to assure their health and well-being may have their individual budget reset to the amount in the cost matrix described in the previous section that most closely matches the transition that they are experiencing, based on their needs. Additional service requests must be based on an assessed need related to the participant’s health and safety. Age does not automatically constitute a change in the individual budget.

Add-On’s to the Individual Budget are preventative services, equipment or support services that will be treated as an add-on to the individual budget. These expenses will not be incorporated into the base budget. Services included in this type of modification are: Assistive

Technology: Equipment and Supplies, Communication Devices, Community Guide for needed start up activities to access the Individual and Family Directed Supports Option , Community Transition Services, Crisis Services, Financial Supports Services, Home Modifications, Natural Support Education and Vehicle Adaptations.

Unexpected Needs are temporary, time-limited modifications to the individual budget that can be authorized when natural and other community supports that are integral to the person's health and well-being will be temporarily unavailable (e.g. due to hospitalization or illness of a caregiver) or when there is a non permanent change in the person's condition that requires the provision of services and supports that exceeds the funding available in their individual budget (e.g. significant changes in behavioral, medical or physical condition of the participant) and increases risks associated with health and well-being. A temporary modification is time limited, does not affect the participant's base individual budget, will not be carried forward to subsequent years. Modifications will be limited to Community Guide Services, Home Supports and Respite.

Other requests for individual budget modifications that do not meet one of the above criteria and that the Care Coordinator considers necessary to meet the disability specific needs of the participant are submitted to the PIHP Clinical Advisory Committee for review. The membership of this panel includes families, participants and professionals who are well versed in developmental disabilities and waiver services. Following the review of the information, a recommendation is made to the PIHP department for final determination and authorization of funding. If requests for funding for any type of service or support are denied, the participant will be provided with his/her right to a fair hearing.

Budget Re-determination

The individual budget is reviewed annually as part of the development of the Individual Support Plan. If there are unexpended funds in the base budget or add-on items within the current budget, this funding is not carried forward to the next plan/budget period. Each successive year the budget returns to the base to begin the Individual Support Plan development. Under expenditure of funds from previous the year will not constitute a reduction in the base budget or have a bearing on self-direction or add-on items in the budget the next year.

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<input type="checkbox"/>	<p>Budget Limits by Level of Support. Based on an assessment process and/or other factors, participants are assigned to funding levels that are limits on the maximum dollar amount of waiver services. <i>Furnish the information specified above.</i></p>
<input type="checkbox"/>	<p>Other Type of Limit. The State employs another type of limit. <i>Describe the limit and furnish the information specified above.</i></p>

Appendix D: Participant-Centered Planning and Service Delivery

Appendix D-1: Service Plan Development

State Participant-Centered Service Plan Title: Individual Support Plan

- a. **Responsibility for Service Plan Development.** Per 42 CFR §441.301(b)(2), specify who is responsible for the development of the service plan and the qualifications of these individuals (*check each that applies*):

<input type="checkbox"/>	Registered nurse, licensed to practice in the State
<input type="checkbox"/>	Licensed practical or vocational nurse, acting within the scope of practice under State law
<input type="checkbox"/>	Licensed physician (M.D. or D.O)
<input type="checkbox"/>	Case Manager (qualifications specified in Appendix C-3)
<input checked="" type="checkbox"/>	Case Manager (qualifications not specified in Appendix C-3). <i>Specify qualifications:</i>
	Qualified Professional as defined in NC G.S.-122 C
	A Qualified Professional is equivalent to the federally defined Qualified Mental Retardation Professional.
<input type="checkbox"/>	Social Worker. <i>Specify qualifications:</i>
<input type="checkbox"/>	Other (<i>specify the individuals and their qualifications</i>):

- b. **Service Plan Development Safeguards.** *Select one:*

<input checked="" type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may not provide</i> other direct waiver services to the participant.
<input type="radio"/>	Entities and/or individuals that have responsibility for service plan development <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that service plan development is conducted in the best interests of the participant. <i>Specify:</i>

- c. **Supporting the Participant in Service Plan Development.** Specify: (a) the supports and information that are made available to the participant (and/or family or legal representative, as appropriate) to direct and be actively engaged in the service plan development process and (b) the participant's authority to determine who is included in the process.

(a) A variety of Person Centered Toolkits are available to gather information and enable the participants to share information with the ISP team. The participant can complete the toolkit with the assistance of the Support Coordinator (case manager) or support providers as needed. Based on the unique needs of the participant a decision can be made to use one toolkit, multiple toolkits or none at all.

(b) The Participant and Support Coordinator review the team composition to make sure that people the Participant would like to have at the meeting are invited. If the participant has a legally responsible person, the Support Coordinator will ensure that the person is invited to the ISP meeting as well.

- d. Service Plan Development Process** In four pages or less, describe the process that is used to develop the participant-centered service plan, including: (a) who develops the plan, who participates in the process, and the timing of the plan; (b) the types of assessments that are conducted to support the service plan development process, including securing information about participant needs, preferences and goals, and health status; (c) how the participant is informed of the services that are available under the waiver; (d) how the plan development process ensures that the service plan addresses participant goals, needs (including health care needs), and preferences; (e) how waiver and other services are coordinated; (f) how the plan development process provides for the assignment of responsibilities to implement and monitor the plan; and, (g) how and when the plan is updated, including when the participant's needs change. State laws, regulations, and policies cited that affect the service plan development process are available to CMS upon request through the Medicaid agency or the operating agency (if applicable):

Individual Support Planning System

The Individual Support Plan (ISP) is developed through a person-centered planning process led by the participant and/or legally responsible person for the participant to the extent they desire. Person-centered planning is about supporting participants to realize their own vision for their lives. It is a process of building effective and collaborative partnerships with participants, and working in partnership with them to create a road map for the ISP, for reaching the participant's goals. The planning process is directed by the participant and identifies strengths and capabilities, desires and support needs. A good person-centered plan is a rich meaningful tool for the participant receiving supports as well as those who provide the supports. It generates actions--positive steps that the participant can take towards realizing a better, more complete life. Good plans also ensure that supports are delivered in a consistent, respectful manner and offer valuable insight into how to access the quality of services being provided. PIHP's Individual Support Plan System Manual provides detailed information about how ISPs are developed.

At the time the participant is entering the waiver, a copy of the Innovations Family Guide is mailed to the participant/family. The participant's Support Coordinator (case manager) is available to answer any questions that the participant/family may have regarding available services. The Guide contains eligibility requirements, service definitions, individual budgeting and information about the planning process. The Support Coordinator works with the participant to develop the ISP. The Support Coordinator determines with the participant and/or legally responsible person to what degree they desire to lead the planning team and identify its membership. If there are sensitive topics that the participant does not want discussed in an open setting, the participant (or parents/guardian) and the Support Coordinator agree as to how these will be handled and with whom they will be discussed. In addition to the participant, parents, legal guardian, and Support Coordinator, additional planning team members may include: support providers, family, friends, acquaintances, and other community supports.

The Initial ISP is completed and submitted to the PIHP for approval, no later than 60 days from the approval of the Piedmont Level of Care tool. Annual Plans are developed to be effective on the first of the month following the participant's birth month.

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Assessments

A variety of assessments are completed to support the planning process including:

Person-Centered Information: This involves identifying what is most important to the participant from their perspective and the perspective of others that care about the participant. It involves identifying the participant's strengths, preferences, and needs through both informal and formal assessment process. A variety of person-centered tool kits are available to assist in getting to know the participant. These toolkits include worksheets, workbooks, and exercises that can be completed by the participant, with the assistance of the Support Coordinator or other support persons as needed.

Piedmont Risk/Support Needs Assessment: This assessment assists the participant and the ISP team in identifying significant risks to the participant's health, safety, financial security, and the safety of others around them. In addition, this assessment identifies needed professional and material supports to ensure the participant's health and safety. Risks identified in this assessment could bring great harm, result in hospitalization, or result in incarceration if needed supports are not in place.

Information about Support Needs: This information assists in assuring that the participant receives needed services, and at the same time, that participants do not receive services that are unnecessary, ineffective, and/or do not effectively address the participant's identified needs. This can include information from the Supports Intensity Scale (SIS), Health/Support Assessment and/or other formal assessment of the participant's support needs.

Additional Formal Evaluations: These are evaluations by professionals and can include physical therapy, occupational therapy, speech therapy, vocational, behavioral, developmental testing, physician recommendations, psychological testing, adaptive behavior scales or other evaluations as needed.

Self Direction Assessment: This is an assessment to determine what types of support the participant or legally responsible person needs to self-direct wavier services if self directed services are requested.

Prior to the Individual Support Planning Meeting:

The Support Coordinator offers the participant/legally responsible person the opportunity to receive an Orientation to Individual and Family Directed Supports. The orientation includes a power point presentation, handouts about the Individual/Family Directed Supports Option, and may include a short video. If the participant/legally responsible person is interested in learning more about Individual/Family Directed Supports, the Support Coordinator arranges for them to receive additional training and information.

The Support Coordinator informs the participant/legally responsible person of the Participant's Individual Budget amount and answers any questions regarding the Budget. The Support Coordinator also provides the amount of the Self-Directed Budget if the Participant/Legally Responsible Person desire to self-direct one or more services.

The Support Coordinator supports the participant to schedule the meeting and invite team members to the meeting at a time and location that is desirable for the participant.

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The Individual Support Plan Meeting

The Participant and Support Coordinator review with the team all issues that were identified during the assessment processes. Information is presented in draft plan form, bulleted notes, large post-it paper, or handouts to team members. Information is organized in a way that allows the participant to work with the team and have open discussion regarding issues to begin action planning.

The planning meeting also includes a discussion about monitoring the participant's services, supports, and health/safety issues. During the planning meeting decisions are made regarding team members responsibilities for service implementation and monitoring. While the Support Coordinator is responsible for overall monitoring of the ISP and the participant's situation, other team members, including the participant, and community supports may be assigned monitoring responsibilities.

Developing the ISP

Based on decisions made during the ISP planning meeting, the Support Coordinator documents the results of the ISP on the Piedmont Individual Support Plan form. The Participant or legally responsible person participates in the determination of the results of the meeting to the degree that they desire.

The ISP addresses the following areas:

- (1) My introduction-Great Things about me
- (2) Relationships in my life
- (3) What has been happening in my life over the past year?
- (4) What do I hope this plan will help me accomplish?
- (5) What would I change about my life?
- (6) What support do I need to maintain important things in my life or make changes to my life? (to include strategies to address identified health, safety risks and any special training/skills that staff need to be able to meet the unique needs of the participant beyond required staff qualifications)
- (7) Status of Individual/Family Direction (includes documentation that the participant/legally responsible person was offered the opportunity to receive orientation to Individual/Family direction and whether the participant/legally responsible person is interested in obtaining more training on this option.
- (8) Risk Summary
- (9) Back Up Staffing Plan
- (10) Action Plan (Outcome, Where am I in relationship to the Outcome?; Service/Support to reach outcome; Who will provide support/service?; Services/Support/Frequency/Target Date)
- (11) Case Management Outcomes
- (12) Issues to be Resolved
- (13) Monitoring Plan
- (14) Individual and Self-Directed Budget (services to be provided, units of services required, period of time, start and end dates for services, rate of service)
- (15) Level of Care Re-determination (for annual plans only)
- (16) Freedom of Choice Statement
- (17) Signatures (includes documentation of provider choice)
- (18) Demographic Page to include diagnostic information
- (19) Crisis Plan as applicable to include strategies to mitigate risk that require additional management

The ISP also includes other formal and informal services and supports that the participant

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wants and/or needs. The ISP provides for supports and coordination for the participant to access school based services, generic community resources and Medicaid state plan services. The Support Coordinator makes sure that the ISP contains a plan for coordinating services, including the Support Coordinator's responsibility for overall plan coordination of waiver and other services.

Once the plan is documented and signed by the participant/legally responsible person the Support Coordinator submits it to the PIHP for approval.

Plan Approval

The ISP approval process by the PIHP verifies that there is a proper match between the participant's needs and the service provided. Once the ISP is approved and services are authorized, the Support Coordinator notifies the participant/legally responsible person of the approval, the services that will be provided, and the start date of services. The participant/legally responsible person is given a copy of the approved ISP and Individual Budget, including Crisis Plan as applicable.

Updates/Changes to the ISP

The Support Coordinator works with the participant and the team to ensure that the ISP is updated with current and relevant information. Timely updates to the ISP help maintain the integrity of the plan by ensuring those changes are communicated and documented consistently. The ISP is updated/revised by adding a new Demographic page and/or using the Update to Individual Support Plan. When the Update to the ISP involves a change in the budget, the Individual Budget page is also updated. Examples of updates/revisions include adding an outcome, addressing needs related to the back-up staffing plan, and adding new information when the participant's needs change.

Transition to the New Waiver

The current approved Individual Support Plan for each participant of the 2005 Innovations waiver will continue to be used until the next annual Individual Support Plan development at the participant's birth month.

- e. **Risk Assessment and Mitigation.** Specify how potential risks to the participant are assessed during the service plan development process and how strategies to mitigate risk are incorporated into the service plan, subject to participant needs and preferences. In addition, describe how the service plan development process addresses backup plans and the arrangements that are used for backup.

The Piedmont Risk/ Support Needs Assessment is completed prior to the development of the ISP and updated as significant changes occur with the participant at least annually. The Support Coordinator works with the participant, family and other team members to complete the assessment.

1. The Piedmont Risk/Support Needs Assessment includes: Health and Wellness screening to include the primary care physician to act as the locus of coordination for all health care issues medication management, nutrition, preventive screenings as appropriate and any relevant information obtained from other Supports Needs Assessments.
2. Risk screening to include behavioral supports, potential mental health issues, personal safety and environmental community risk issues.

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Support needs and potential risks that are identified during the assessment process are addressed in the ISP which includes a Crisis Plan as applicable. Strategies to mitigate the risk reflect participant needs and include consideration of the participant preferences. Strategies to mitigate risk may include the use of risk agreements.

The ISP states who and how risks will be monitored including the paid providers, natural and community supports, participants and their family, and the Support Coordinator.

A Back Up Staffing Plan is included in the ISP and designed to meet the needs of participants to make sure that their health and safety is assured. It outlines who (whether natural or paid) is available, contact numbers, At least two levels of back-up staffing are identified for each waiver service provided.

- f. **Informed Choice of Providers.** Describe how participants are assisted in obtaining information about and selecting from among qualified providers of the waiver services in the service plan.

The Support Coordinator, following the PIHP policy, assists the participant/legally responsible person in choosing a qualified provider to implement each service in the ISP. The Support Coordinator meets with the participant/legally responsible person and provides them with a provider listing of each qualified provider within the PIHP provider network and encourages the individual /legally responsible person to select providers that they would like to meet to obtain further information. The Support Coordinator provides any additional information that may be helpful in assisting them to choose a provider. Arranging provider interviews is facilitated by the Support Coordinator on behalf of the participant. Once the participant has selected a provider, their choice of provider is documented in the service record.

- g. **Process for Making Service Plan Subject to the Approval of the Medicaid Agency.** Describe the process by which the service plan is made subject to the approval of the Medicaid agency in accordance with 42 CFR §441.301(b)(1)(i):

The PIHP approves Individual Service Plans (ISP) following a process approved by the Division of Medical Assistance (DMA), the State Medicaid agency. Individual Support Plan (Service Plan) approval occurs locally at the PIHP. DMA authorizes the PIHP to approve Individual Support Plans through routine monitoring of the Plan of Care Approval Process. DMA may revoke approval authority if it determines that the LME is not in compliance with the waiver requirements. In the case of a revocation, the plan of care approval would be carried out by DMA or DMA designee.

- h. **Service Plan Review and Update.** The service plan is subject to at least annual periodic review and update to assess the appropriateness and adequacy of the services as participant needs change. *Specify the minimum schedule for the review and update of the service plan:*

<input type="radio"/>	Every three months or more frequently when necessary
<input type="radio"/>	Every six months or more frequently when necessary
<input checked="" type="radio"/>	Every twelve months or more frequently when necessary
<input type="radio"/>	Other schedule (<i>specify</i>):

- . **Maintenance of Service Plan Forms.** Written copies or electronic facsimiles of service plans are maintained for a minimum period of 3 years as required by 45 CFR §74.53. Service plans are maintained by the following (*check each that applies*):

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<input type="checkbox"/>	Medicaid agency
<input type="checkbox"/>	Operating agency
<input checked="" type="checkbox"/>	Case manager
<input checked="" type="checkbox"/>	Other (<i>specify</i>):
	PIHP

Appendix D-2: Service Plan Implementation and Monitoring

- a. **Service Plan Implementation and Monitoring.** Specify: (a) the entity (entities) responsible for monitoring the implementation of the service plan and participant health and welfare; (b) the monitoring and follow-up method(s) that are used; and, (c) the frequency with which monitoring is performed.

The administrative case management unit, a division of the PIHP, is responsible for monitoring the implementation of the Individual Support Plan. Services are implemented within 45 days of Individual Support Plan approval. The Support Coordinator (administrative case manager) is responsible for the monitoring activities. Monitoring will take place in all service settings and on a schedule outlined in the ISP.

Monitoring methods also include contacts (face to face and telephone calls) with other members of the ISP team and review of service documentation. A standard monitoring check list is used to ensure that the following issues are monitored:

- (1) Verification that services are provided as outlined in the ISP,**
- (2) Participants have access to services and identification of any problems that may arise,**
- (3) The services meet the needs of the participants, that the back-up staffing plans are documented,**
- (4) Issues of health and welfare (rights restrictions, medical care, abuse/neglect/exploitation, behavior support plan) are addressed and that participants are offered a free choice of providers and that non waiver services needs have been addressed.**

Support Coordinator monitoring occurs monthly to include the following:

- (1) Participants that are new to the waiver receive face to face visits for the first six months and then on a schedule agreed to by the ISP team thereafter, no less than quarterly, to meet their health and safety needs.**
- (2) Participants whose services are provided by guardians and relatives living in the home of the participant receive monthly face to face monitoring visits.**
- (3) Participants who live in residential programs receive face to face monitoring visits monthly.**
- (4) Participants who choose the Individual Family Directed Service option receive face to face monitoring visits monthly.**
- (5) For months that participants do not receive face to face monitoring, the Support Coordinator has telephone contact to ensure that there are no issues that need to be addressed.**

- b. **Monitoring Safeguards.** *Select one:*

- ☒ Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare *may not provide* other direct waiver services to the participant.

○	Entities and/or individuals that have responsibility to monitor service plan implementation and participant health and welfare <i>may provide</i> other direct waiver services to the participant. The State has established the following safeguards to ensure that monitoring is conducted in the best interests of the participant. <i>Specify:</i>

Quality Management: Service Plan

As a distinct component of the State's quality management strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a Methods for Discovery: Service Plan Assurance and Subassurances

a.i.a *Service plans address all participants' assessed needs (including health and safety risk factors) and personal goals, either by the provision of waiver services or through other means.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of Individual Support Plans in which the services and supports reflect participant assessed needs and life goals		
Data Source Record Reviews off-site PIHP program log	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify:	
		Semi-Annually	<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report

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	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Other: Specify: semi-annually	

Performance Measure:	Proportion of Individual Support Plans that address identified health and safety risk factors		
Data Source Record Reviews off-site PIHP program log	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input checked="" type="checkbox"/> Other: Specify: Semi-Annually	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Other: Specify: Semi-Annually	

Performance Measure:	Proportion of participants reporting that their Individual Support Plan has the services that they need
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Data Source Record Reviews off site	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other: Specify: Semi-Annually	

a.i.b The State monitors service plan development in accordance with the approved waiver and takes appropriate action when it identifies inadequacies in service plan development.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

Performance Measure:	The State requires the PIHP to report results of performance measures related to the service plan to DMA and the Intra-Departmental Monitoring Team (IMT) and requires corrective action as appropriate. Corrective action is monitored at minimum quarterly by DMA and the IMT.		
Data Source PIHP reports on service plan performance measures	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)

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	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input type="checkbox"/> <i>Representative Sample</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input checked="" type="checkbox"/> <i>Quarterly(Corrective action plan monitoring)</i>	
	<input checked="" type="checkbox"/> <i>Other: Specify:PIHP</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
		<input checked="" type="checkbox"/> <i>Other: Specify: Semi-Annually (Reporting on measures by PIHP)</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other: Specify</i>
	<input checked="" type="checkbox"/> <i>Other: Specify:PIHP</i>	<input type="checkbox"/> <i>Annually</i>	
		<input checked="" type="checkbox"/> <i>Other: Specify:Semi-Annually</i>	

a.i.c *Service plans are updated/revised at least annually or when warranted by changes in the waiver participant's needs.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of individuals whose needs change during the year for whom an appropriate plan update took place		
Data Source Record Reviews off site Analyze collected data	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>Representative Sample</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Case Management</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>	<i>ISP update</i>

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	<i>Agency</i>		
	<input checked="" type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
	<i>PIHP</i>	<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>Narrative Report</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input checked="" type="checkbox"/> <i>Data Compilation</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input type="checkbox"/> <i>Quarterly</i>	<input type="checkbox"/> <i>Other: Specify</i>
	<input checked="" type="checkbox"/> <i>Other: Specify:</i>	<input checked="" type="checkbox"/> <i>Annually</i>	
	<i>PIHP</i>	<input type="checkbox"/> <i>Other: Specify:</i>	

a.i.d Services are delivered in accordance with the service plan, including the type, scope, amount, duration, and frequency specified in the service plan

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of new waiver participants who are receiving services according to their Individual Service Plan within 45 days of Individual Support Plan approval		
Data Source Record Reviews on site Analyze collected data Record Reviews off site Financial records	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> <i>State Medicaid Agency</i>	<input type="checkbox"/> <i>Weekly</i>	<input checked="" type="checkbox"/> <i>Representative Sample</i>
	<input type="checkbox"/> <i>Operating Agency</i>	<input type="checkbox"/> <i>Monthly</i>	<input type="checkbox"/> <i>100% Review</i>
	<input type="checkbox"/> <i>Case Management Agency</i>	<input checked="" type="checkbox"/> <i>Quarterly</i>	
	<input checked="" type="checkbox"/> <i>Other: Specify:</i>	<input type="checkbox"/> <i>Annually</i>	<input type="checkbox"/> <i>Stratified: Describe Group</i>
	<i>PIHP</i>	<input type="checkbox"/> <i>Other: Specify:</i>	
			<input type="checkbox"/> <i>Other: Describe</i>

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Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	
		Annually	

Performance Measure:	Proportion of waiver participants who are receiving services in the type, scope, amount, and frequency as specified in the Individual Support Plan		
Data Source Record Reviews on site Record Reviews off site Analyze collected data Financial records	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	
	PIHP	<input checked="" type="checkbox"/> Other: Specify:	

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Semi Annually

a.i.e Participants are afforded choice: Between waiver services and institutional care; and between/among waiver services and providers.

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of records that contain a signed freedom of choice statement		
Data Source Record Review on site PIHP program log	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other: Specify:	

Performance Measure:	Proportion of participants reporting their Support Coordinator helps them to know what waiver services are available		
Data Source Record Review on	Responsible Party for data	Frequency of data collection/generation:	Sampling Approach

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site	collection/generation (check each that applies)	(check each that applies)	(check each that applies)
Analyze collected data			
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other: Specify:	

Performance Measure:	Proportion of participants reporting that they have a choice between providers		
Data Source	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
Record Review on site			
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
	PIHP	<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe

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Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
	PIHP	<input type="checkbox"/> Other: Specify:	

- a.ii If applicable, in the textbox below provide any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation

- b.i Describe the States strategy for addressing individual problems as they are discovered.

The PIHP will address and correct problems identified on a case by case basis and include the information in the report to DMA and the Intra-departmental Monitoring Team. DMA may require a corrective action plan if the problems identified appear to require a change in the PIHP's processes for developing, implementing and monitoring service plans. DMA monitors the corrective action plan with the assistance of the Intra-Departmental Monitoring Team.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation

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	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input checked="" type="radio"/>	Yes (complete remainder of item)
<input type="radio"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

Reviews by the PIHP for a.i.c. and a.i.d. will begin 12-01-08.

Appendix E: Participant Direction of Services

[NOTE: Complete Appendix E only when the waiver provides for one or both of the participant direction opportunities specified below.]

Applicability (select one):

<input checked="" type="radio"/>	Yes. This waiver provides participant direction opportunities. Complete the remainder of the Appendix.
<input type="radio"/>	No. This waiver does not provide participant direction opportunities. Do not complete the remainder of the Appendix.

CMS urges states to afford all waiver participants the opportunity to direct their services. Participant direction of services includes the participant exercising decision-making authority over workers who provide services, a participant-managed budget or both. CMS will confer the Independence Plus designation when the waiver evidences a strong commitment to participant direction. Indicate whether Independence Plus designation is requested (select one):

<input checked="" type="radio"/>	Yes. The State requests that this waiver be considered for Independence Plus designation.
<input type="radio"/>	No. Independence Plus designation is not requested.

Appendix E-1: Overview

- a. Description of Participant Direction.** In no more than two pages, provide an overview of the opportunities for participant direction in the waiver, including: (a) the nature of the opportunities afforded to participants; (b) how participants may take advantage of these opportunities; (c) the entities that support individuals who direct their services and the supports that they provide; and, (d) other relevant information about the waiver's approach to participant direction.

The Innovations Waiver offers participants both Agency Directed and Participant Directed Service Options. Participant Directed Services are known as Individual and Family Directed Services. The 2005 Innovations Waiver provides the opportunity for participants or the legally responsible person for that participant to be the Employer of Record. Because interest has been expressed in the Agency with Choice Model of Participant Directed Services, the PIHP proposes to add this model to the Innovations Waiver.

All Waiver participants are offered the opportunity to direct one or more of the following services: Community Guide; Community Networking; Home Supports; Natural Supports Education; Respite; and Supported Employment.

Participants are offered an opportunity to receive an Orientation to Individual and Family Directed Supports Meeting from the Support Coordinator (Administrative Case Manager) at the time of the Initial or Annual Plan. The Orientation consists of a Power Point presentation presented by the Support Coordinator, a short video, and handouts describing the option. The Support Coordinator informs participants that additional training on Individual and Family Directed Services is available from a Community Guide. The Community Guide is a provider that assists participants in locating and coordinating community resources and with direct

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assistance in participant direction activities. The Support Coordinator includes Community Guide Services in the Individual Support Plan as directed by participants. Community Guide Services for the purpose of training and support in implementing Individual and Family Directed Supports are available to participants without charge to the Individual Budget.

When a participant and/or legally responsible person express interest in directing services, they receive additional training from a Community Guide. The Community Guide also provides the participant/legally responsible person with a copy of an Employer Handbook and other educational materials. The training and educational materials provide sufficient information to ensure that the participant and/or legally responsible person make informed choices about the degree they wish to self-direct services.

After the training, the participant and/or legally responsible person meet with a Support Coordinator. The Employer of Record or Managing Employer is identified. The Employer of Record or Managing Employer is the participant, the parent of a minor participant, or the guardian of the participant. If a Representative is desired or needed to assist in directing services, the Support Coordinator assists in the appointment of the representative. The Support Coordinator assesses the Employer of Record, Managing Employer, and Representative, if applicable, to determine the areas of support needed to self-direct services. Standard assessment tools are used with each Employer, Managing Employer, and/or Representative.

The participant and/or legally responsible person direct the Support Coordinator to add the requested model of Individual and Family Directed Supports, either Employer of Record or Agency with Choice, to the Individual Support Plan (ISP) and select the services that are to be self-directed. Services are directed to the extent that the participant and/or legally responsible person desire. Services that may be self-directed include: Community Guide Services; Community Network Services; Home Supports; Individual Goods and Services; Natural Support Education; Respite Services; and Supported Employment Services. The participant may direct one or all of these services, and may receive additional provider directed services that the participant does not choose to self-direct.

The participant, legally responsible person, and Support Coordinator work collaboratively to include supports for self-direction in the ISP that may include additional Community Guide Services. The participant and legally responsible person also choose either a Financial Supports Agency or Agency with Choice, depending on the model of Individual and Family Directed Supports elected. The completed ISP is submitted to the PIHP for approval. Emergency and back-up staffing plans are included.

Once the ISP is approved, a referral is made to a Financial Supports agency for participants who have elected the Employer of Record Model. The Financial Supports Agency assists by assuring that services are managed and funds distributed as needed. The Financial Supports agency also assists with required paperwork that is submitted to the Internal and State Revenue Services, and facilitates the employment of support staff. The Employer of Record screens, hires, and trains staff. The Employer of Record manages the Individual and Family Directed (participant-directed) budget by setting employee pay rates and benefits through the use of a computer based Auto Calculator. Community Guides are able to assist Employers who do not have access to computers with the auto calculator and other web based resources. The Employer of Record provides the supervision of the staff in lieu of supervision that would normally be provided by a Qualified Professional in a provider directed employment arrangement. If necessary, the Employer dismisses employees.

For participants who elect the Agency with Choice Model, a referral is made to an Agency with

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Choice. The Agency with Choice serves as the Common Law Employer for employees providing services to the participant. The Managing Employer screens, interviews, and recommends applicants for hire. Managing Employers and the Agency with Choice jointly ensure that employees are trained. The Managing Employer provides supervision of staff with oversight by a Qualified Professional employed by the Agency with Choice. If necessary, the Managing Employer dismisses or recommends dismissal of employees.

In both models, Agreements with the PIHP, the Financial Supports Agency, Agency with Choice and employees outline responsibilities of all parties in the Individual and Family Directed Support Option. Community Guides assist the Employer or Managing Employer with employer duties and responsibilities as requested or needed. Participants in either model of Individual and Family Directed Supports have access to Individual Goods and Services when employees begin work.

The PIHP provides on-going support for Individual and Family Directed Supports by maintaining a web site with information about Individual and Family Directed Supports. The PIHP also provides the opportunity for a web forum that allows Employers and Managing Employers to communicate to share experiences with Individual and Family Directed Supports. The PIHP also arranges periodic meetings for Employers and Managing Employers that provide opportunities for meetings with key support agencies including Support Coordinators, Community Guides, Agencies with Choice and Financial Supports Agencies.

The PIHP monitors Individual and Family Directed Supports by annual monitoring of participants in Individual and Family Directed Supports and Financial Supports Agency. Community Guide Agencies and Agencies with Choice are monitored at least once every three years at a frequency determined by the PIHP. Participants in Individual and Family Directed Supports may elect to return to Provider Directed Services at any time by informing the Support Coordinator. The PIHP may remove a participant from Individual and Family Supports, after consultation with the Division of Medical Assistance, in instances when the participant's health and safety are compromised, or after an Employer or Managing Employer has made the same major mistake three different times in one year.

- b. **Participant Direction Opportunities.** Specify the participant direction opportunities that are available in the waiver. *Select one:*

<input type="radio"/>	Participant – Employer Authority. As specified in <i>Appendix E-2, Item a</i> , the participant (or the participant's representative) has decision-making authority over workers who provide waiver services. The participant may function as the common law employer or the Agency with Choice of workers. Supports and protections are available for participants who exercise this authority.
<input type="radio"/>	Participant – Budget Authority. As specified in <i>Appendix E-2, Item b</i> , the participant (or the participant's representative) has decision-making authority over a budget for waiver services. Supports and protections are available for participants who have authority over a budget.
<input checked="" type="radio"/>	Both Authorities. The waiver provides for both participant direction opportunities as specified in <i>Appendix E-2</i> . Supports and protections are available for participants who exercise these authorities.

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c. Availability of Participant Direction by Type of Living Arrangement. *Check each that applies:*

<input checked="" type="checkbox"/>	Participant direction opportunities are available to participants who live in their own private residence or the home of a family member.
<input checked="" type="checkbox"/>	Participant direction opportunities are available to individuals who reside in other living arrangements where services (regardless of funding source) are furnished to fewer than four persons unrelated to the proprietor.
<input checked="" type="checkbox"/>	The participant direction opportunities are available to persons in the following other living arrangements (<i>specify</i>): Participants that live in facilities larger than 3 beds have the option to direct their Community Guide, Community Networking, and Supported Employment Services.

d. Election of Participant Direction. Election of participant direction is subject to the following policy (*select one*):

<input type="radio"/>	Waiver is designed to support only individuals who want to direct their services.
<input checked="" type="radio"/>	The waiver is designed to afford every participant (or the participant's representative) the opportunity to elect to direct waiver services. Alternate service delivery methods are available for participants who decide not to direct their services.
<input type="radio"/>	The waiver is designed to offer participants (or their representatives) the opportunity to direct some or all of their services, subject to the following criteria specified by the State. Alternate service delivery methods are available for participants who decide not to direct their services or do not meet the criteria. <i>Specify the criteria:</i>

e. Information Furnished to Participant. Specify: (a) the information about participant direction opportunities (e.g., the benefits of participant direction, participant responsibilities, and potential liabilities) that is provided to the participant (or the participant's representative) to inform decision-making concerning the election of participant direction; (b) the entity or entities responsible for furnishing this information; and, (c) how and when this information is provided on a timely basis.

General orientation on the two models of the Individual /Family Directed Supports Option, Employer of Record and Agency with Choice, is provided to all waiver participants when they enter the waiver and annually as part of the development of their Individual Support Plan by the Support Coordinator. A Power Point presentation and fact sheets on Individual and Family Directed Supports are provided to the Participant.

If the participant/legally responsible person is interested in electing one of the Individual/Family Direction Models, they will receive training on the roles and responsibilities, and the advantages and potential liabilities of participation in the Option and each Model. The Community Guide Agency is responsible for training and provision of educational materials to include the Employer Handbook and resource materials at the time of training. If the participant has chosen one of the two models of Individual/Family Directed Supports, they will receive ongoing training per specified areas in their Individual Support Plan.

f. Participant Direction by a Representative. Specify the State's policy concerning the direction of waiver services by a representative (*select one*):

<input type="radio"/>	The State does not provide for the direction of waiver services by a representative.
<input checked="" type="radio"/>	The State provides for the direction of waiver services by a representative. Specify the

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		representatives who may direct waiver services: <i>(check each that applies)</i> :
	■	Waiver services may be directed by a legal representative of the participant.
	■	<p>Waiver services may be directed by a non-legal representative freely chosen by an adult participant. Specify the policies that apply regarding the direction of waiver services by participant-appointed representatives, including safeguards to ensure that the representative functions in the best interest of the participant:</p> <p>In the Individual and Family Directed Supports Option, the adult waiver participant, parent(s) of the minor participant or legal guardian is designated as the Employer of Record or Managing Employer. That person is assessed to determine if help is needed to manage supports. If help is needed, a person will be named to provide this assistance. This person is known as a Mandated Representative. If one is not required, a Voluntary Representative may still be appointed. The Representative may be a family member, friend, someone who has power of attorney, income payee, or another person who willingly accepts responsibility for performing tasks that the participant is unable to perform.</p> <p>The Representative must meet the following requirements:</p> <ol style="list-style-type: none"> 1. Demonstrate knowledge and understanding of the participant's needs and preferences and respect these preferences, 2. Evidence of a personal commitment to the participant and be willing to follow the individual's wishes while using sound judgment to act on the participant's behalf, 3. Agree to a predetermined level of contact with the participant, 4. Be at least 18 years of age, 5. Be willing and able to comply with program requirements, be approved by the participant or his/her legal representative to act in this capacity. <p>The Representative may not:</p> <ol style="list-style-type: none"> 1. Be paid for being the representative, 2. Provide paid services to the participant, including employees of Agencies providing services, with the exception of guardianship services, 3. Have a history of physical, mental, or financial abuse.

- g. **Participant-Directed Services.** Specify the participant direction opportunity (or opportunities) available for each waiver service that is specified as participant-directed in Appendix C-3. *(Check the opportunity or opportunities available for each service):*

Participant-Directed Waiver Service	Employer Authority	Budget Authority
Community Guide	■	■
Community Network	■	■
Home Supports	■	■
Individual Goods and Services	■	■
Natural Support Education	■	■
Respite	■	■
Supported Employment	■	■

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- h. Financial Management Services.** Except in certain circumstances, financial management services are mandatory and integral to participant direction. A governmental entity and/or another third-party entity must perform necessary financial transactions on behalf of the waiver participant. *Select one:*

<input checked="" type="radio"/>	Yes. Financial Management Services are furnished through a third party entity. <i>(Complete item E-1-i). Specify whether governmental and/or private entities furnish these services. Check each that applies:</i>
<input type="checkbox"/>	Governmental entities
<input checked="" type="checkbox"/>	Private entities
<input type="radio"/>	No. Financial Management Services are not furnished. Standard Medicaid payment mechanisms are used. <i>Do not complete Item E-1-i.</i>

- i. Provision of Financial Management Services.** Financial management services (FMS) may be furnished as a waiver service or as an administrative activity. *Select one:*

<input checked="" type="radio"/>	FMS are covered as the waiver service entitled Financial Support Services as specified in Appendix C-3. <i>Provide the following information:</i>														
<input type="radio"/>	FMS are provided as an administrative activity. <i>Provide the following information:</i>														
i.	Types of Entities: Specify the types of entities that furnish FMS and the method of procuring these services: Agencies under contract with and approved by the PIHP who meet the qualifications for Financial Supports listed in Appendix C. The PIHP uses a standardized process to request information or proposals from provider agencies within the provider network who may have interest or expertise in providing these services.														
ii.	Payment for FMS. Specify how FMS entities are compensated for the administrative activities that they perform: The PIHP sets rates for the Financial Support Service by analyzing the cost of the tasks the Financial Supports Agency is required to perform and the frequency these activities are performed. A monthly rate is established with the Financial Support Agency billing the actual cost of start-up costs (initial employee training, initial supplies, etc.).														
iii.	Scope of FMS. Specify the scope of the supports that FMS entities provide <i>(check each that applies):</i> <i>Supports furnished when the participant is the employer of direct support workers:</i> <table border="1"> <tr> <td><input checked="" type="checkbox"/></td> <td>Assist participant in verifying support worker citizenship status</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Collect and process timesheets of support workers</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Other <i>(specify):</i> Requests criminal background, drivers checks and healthcare registry checks on behalf of the Employer of Record</td> </tr> </table> <i>Supports furnished when the participant exercises budget authority:</i> <table border="1"> <tr> <td><input checked="" type="checkbox"/></td> <td>Maintain a separate account for each participant's participant-directed budget</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Track and report participant funds, disbursements and the balance-of participant funds</td> </tr> <tr> <td><input checked="" type="checkbox"/></td> <td>Process and pay invoices for goods and services approved in the service plan</td> </tr> </table>	<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status	<input checked="" type="checkbox"/>	Collect and process timesheets of support workers	<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance	<input checked="" type="checkbox"/>	Other <i>(specify):</i> Requests criminal background, drivers checks and healthcare registry checks on behalf of the Employer of Record	<input checked="" type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget	<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds	<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan
<input checked="" type="checkbox"/>	Assist participant in verifying support worker citizenship status														
<input checked="" type="checkbox"/>	Collect and process timesheets of support workers														
<input checked="" type="checkbox"/>	Process payroll, withholding, filing and payment of applicable federal, state and local employment-related taxes and insurance														
<input checked="" type="checkbox"/>	Other <i>(specify):</i> Requests criminal background, drivers checks and healthcare registry checks on behalf of the Employer of Record														
<input checked="" type="checkbox"/>	Maintain a separate account for each participant's participant-directed budget														
<input checked="" type="checkbox"/>	Track and report participant funds, disbursements and the balance-of participant funds														
<input checked="" type="checkbox"/>	Process and pay invoices for goods and services approved in the service plan														

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<input checked="" type="checkbox"/>	Provide participant with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other services and supports (<i>specify</i>):
<i>Additional functions/activities:</i>	
<input type="checkbox"/>	Execute and hold Medicaid provider agreements as authorized under a written agreement with the Medicaid agency
<input checked="" type="checkbox"/>	Receive and disburse funds for the payment of participant-directed services under an agreement with the Medicaid agency or operating agency
<input checked="" type="checkbox"/>	Provide other entities specified by the State with periodic reports of expenditures and the status of the participant-directed budget
<input type="checkbox"/>	Other (<i>specify</i>):
iv.	<p>Oversight of FMS Entities. Specify the methods that are employed to: (a) monitor and assess the performance of FMS entities, including ensuring the integrity of the financial transactions that they perform; (b) the entity (or entities) responsible for this monitoring; and, (c) how frequently performance is assessed.</p> <p>The Financial Supports Agency is monitored at least annually by the PIHP. A standard instrument is used to review all Financial Supports agency responsibilities and systems. In addition, the PIHP monitors incidents and complaints that are submitted. The Financial Supports Agency is required to maintain a complaint log and conduct Satisfaction Surveys. The results of the complaint logs and Satisfaction Surveys are submitted to the PIHP.</p>

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- j. Information and Assistance in Support of Participant Direction.** In addition to financial management services, participant direction is facilitated when information and assistance are available to support participants in managing their services. These supports may be furnished by one or more entities, provided that there is no duplication. Specify the payment authority (or authorities) under which these supports are furnished and, where required, provide the additional information requested (*check each that applies*):

<input type="checkbox"/>	Case Management Activity. Information and assistance in support of participant direction are furnished as an element of Medicaid case management services. <i>Specify in detail the information and assistance that are furnished through case management for each participant direction opportunity under the waiver:</i>
<input checked="" type="checkbox"/>	Waiver Service Coverage. Information and assistance in support of participant direction are provided through the waiver service coverage (s) specified in Appendix C-3 entitled: <div style="border: 1px solid black; display: inline-block; padding: 2px 5px; margin-top: 5px;">Community Guide</div>
<input type="checkbox"/>	Administrative Activity. Information and assistance in support of participant direction are furnished as an administrative activity. <i>Specify: (a) the types of entities that furnish these supports; (b) how the supports are procured and compensated; (c) describe in detail the supports that are furnished for each participant direction opportunity under the waiver; (d) the methods and frequency of assessing the performance of the entities that furnish these supports; and, (e) the entity or entities responsible for assessing performance:</i>

- k. Independent Advocacy** (*select one*).

<input checked="" type="radio"/>	Yes. Independent advocacy is available to participants who direct their services. <i>Describe the nature of this independent advocacy and how participants may access this advocacy:</i>
Independent Advocacy is available through advocacy organizations. Participants are notified upon entry to the Waiver of the availability of self-referral to an advocacy organization, how to contact the PIHP Consumer Affairs Office, and how to contact the state Care-Line if information is desired, independent of the PIHP. Support Coordinators and Community Guides are also able to assist participants and families in obtaining independent advocacy services.	
<input type="radio"/>	No. Arrangements have not been made for independent advocacy.

- l. Voluntary Termination of Participant Direction.** Describe how the State accommodates a participant who voluntarily terminates participant direction in order to receive services through an alternate service delivery method, including how the State assures continuity of services and participant health and welfare during the transition from participant direction:

<p>A participant in Individual and Family Directed Supports may withdraw from the Option at any time by notifying the Support Coordinator. The Support Coordinator prepares a revision to the ISP, and submits the revision to the PIHP so that Provider Directed Services are authorized for the participant with no service lapse. The following steps are followed:</p> <p>(1) Employer or Managing Employer requests that the Support Coordinator terminate Individual and Family Directed Services Option, and return the Participant to Provider Directed Services.</p> <p>(2) Support Coordinator asks the Employer or Managing Employer to select a provider and updates the Individual Support Plan to reflect termination of Individual and Family Directed Services and the provider agency selected by the Employer or Managing Employer</p>

- to provide Provider Directed Services.
- (3) The legally responsible person signs the Individual Support Plan, and the Support Coordinator submits it to the PIHP for approval.
 - (4) The PIHP approves the ISP, authorizes Provider Directed Services, and terminates Financial Supports Services.
 - (5) The PIHP sends a letter to the legally responsible person, Financial Supports Services and Community Guide, and Agency with Choice notifying them of the termination of Individual and Family Directed Services per the legally responsible person's request the date of the termination of payroll to employees. The letter is copied to the Support Coordinator and DMA.
 - (6) The Employer of Record or Agency with Choice Model notifies staff that they are no longer employed under the Individual and Family Directed Services option.
 - (7) The Finance Department reconciles the Individual Budget with the Financial Services Agency. Any non-used funds are returned to PBH by the Financial Services Agency.

- m. **Involuntary Termination of Participant Direction.** Specify the circumstances when the State will involuntarily terminate the use of participant direction and require the participant to receive provider-managed services instead, including how continuity of services and participant health and welfare is assured during the transition.

A participant in Individual and Family Directed Supports may be removed from Individual and Family Directed Services involuntarily under the following circumstances:

- (1) Immediate health and safety concern, including maltreatment of the Participant
- (2) Repeated unapproved expenditures/misuse of Innovations funds
- (3) No approved Representative available when the Employer of Record/Managing Employer in the Agency with Choice Option is determined to need one
- (4) Refusal to accept the necessary Community Guide Services
- (5) Refusal to allow Support Coordinator to monitor services
- (6) Refusal to participate in PIHP, state, or federal monitoring
- (7) Non-compliance with Individual and Family Supports, Financial Support Services, Agency with Choice and/or Employee Support Agreements
- (8) Inability to implement the approved ISP or comply with Innovations requirements despite reasonable efforts to provide additional technical assistance and support (4th event requiring additional technical assistance/corrective action plan in twelve months).

Normally, Employers or Managing Employers in Individual and Family Directed Supports are terminated from the Individual and Family Directed Services Option if the same major mistake occurs more than three times in a twelve month period. However, the recommendation can occur at any point when the Participant's health and safety are at risk or misuse of funds is suspected. For example, an incident of substantiated abuse by a paid employee could lead to termination if a plan cannot be implemented to assure health and safety. If it is determined at any point in the PIHP investigation that the person immediately needs to be returned to the Provider Directed Option to ensure their health and safety this can be recommended. The following steps are followed:

- (2) Concerns and/or allegations of major problems with the implementation of Individual and Family Directed Supports are reported to the PIHP.
- (3) The PIHP Consultant investigates the concerns or allegations of major problems. The Consultant will review all available plans of correction and documentation.
- (4) Depending on results of the investigation, the Consultant may recommend termination of Individual and Family Directed Services. This decision is reviewed with the PIHP Clinical Advisory Committee. The Committee makes a recommendation regarding termination of Individual and Family Directed Services.

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- (5) If the PIHP agrees with the recommendation of the Clinical Advisory Committee, the PIHP arranges a conference call with DMA with involvement from all needed PIHP units to review the situation. If DMA concurs with the PIHP decision, the Employer, Managing Employer and/or Representative, if applicable, as well as the Support Coordinator, are notified of the decision.**
- (6) If the removal is an emergency, the PIHP or the Support Coordinator, contacts the Office of the Medical Director and obtains a decision regarding removal. This decision is reported to Division of Medical Assistance the first working day following the removal.**
- (7) Termination from the Individual and Family Directed Services Option is normally at the end of a month; however, when the termination is due to a threat to the Participant's health and safety, such as physical abuse, termination should occur immediately, and Provider Directed Services should resume immediately.**
- (8) If the Employer/Agency with Choice disagrees with the decision of the PIHP/DMA, the Employer/Agency with Choice may file a reconsideration request or a grievance.**
- (9) Steps 2 through 8 of the Voluntary Termination procedure are followed to return the participant to the Provider Directed Supports option.**

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- n. Goals for Participant Direction.** In the following table, provide the State's goals for each year that the waiver is in effect for the unduplicated number of waiver participants who are expected to elect each applicable participant direction opportunity. Annually, the State will report to CMS the number of participants who elect to direct their waiver services.

Table E-1-n		
	Employer Authority Only	Budget Authority Only or Budget Authority in Combination with Employer Authority
Waiver Year	Number of Participants	Number of Participants
Year 1		288
Year 2		288
Year 3		288
Year 4 (renewal only)		288
Year 5 (renewal only)		288

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Appendix E-2: Opportunities for Participant-Direction

a. Participant – Employer Authority (Complete when the waiver offers the employer authority opportunity as indicated in Item E-1-b)

i. Participant Employer Status. Specify the participant's employer status under the waiver. Check each that applies:

<input checked="" type="checkbox"/>	Participant/Agency with Choice. The participant (or the participant's representative) functions as the Agency with Choice (managing employer) of workers who provide waiver services. An agency is the common law employer of participant-selected/recruited staff and performs necessary payroll and human resources functions. Supports are available to assist the participant in conducting employer-related functions. <i>Specify the types of agencies (a.k.a., "agencies with choice") that serve as Agency with Choices of participant-selected staff; the standards and qualifications the State requires of such entities and the safeguards in place to ensure that individuals maintain control and oversight of the employee:</i>
	Agencies with Choice are Provider Agencies who meet the qualifications for service delivery of all Innovations Service that may be directed under the Individual and Family Supports Option. The PIHP requires specific assurances that are included in each Provider Agency's contract that require the Agency with Choice to maintain policies and procedures that support the control and oversight by participants and/or Managing Employers over Employees. These policies and procedures are subject to approval by the PIHP. Agencies with Choice must attend PIHP sponsored trainings and participant/family meetings in Individual and Family Directed Supports.
<input checked="" type="checkbox"/>	Participant/Common Law Employer. The participant (or the participant's representative) is the common law employer of workers who provide waiver services. An IRS-approved Fiscal/Employer Agent functions as the participant's agent in performing payroll and other employer responsibilities that are required by federal and state law. Supports are available to assist the participant in conducting employer-related functions.

ii. Participant Decision Making Authority. The participant (or the participant's representative) has decision making authority over workers who provide waiver services. Check the decision making authorities that participants exercise:

<input checked="" type="checkbox"/>	Recruit staff
<input checked="" type="checkbox"/>	Refer staff to agency for hiring (Agency with Choice)
<input type="checkbox"/>	Select staff from worker registry
<input checked="" type="checkbox"/>	Hire staff (common law employer)
<input checked="" type="checkbox"/>	Verify staff qualifications
<input checked="" type="checkbox"/>	Obtain criminal history and/or background investigation of staff. Specify how the costs of such investigations are compensated:
	Component part of Financial Support Services; conducted by Agency with Choice for all applicants referred by the Managing Employer and compensated by service rate
<input checked="" type="checkbox"/>	Specify additional staff qualifications based on participant needs and preferences so long as such qualifications are consistent with the qualifications specified in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff duties consistent with the service specifications in Appendix C-3.
<input checked="" type="checkbox"/>	Determine staff wages and benefits subject to applicable State limits (common law employer)
<input checked="" type="checkbox"/>	Schedule staff

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<input checked="" type="checkbox"/>	Orient and instruct-staff in duties
<input checked="" type="checkbox"/>	Supervise staff
<input checked="" type="checkbox"/>	Evaluate staff performance
<input checked="" type="checkbox"/>	Verify time worked by staff and approve time sheets
<input checked="" type="checkbox"/>	Discharge staff (common law employer)
<input checked="" type="checkbox"/>	Discharge staff from providing services (Agency with Choice)
<input type="checkbox"/>	Other (<i>specify</i>):

b. Participant – Budget Authority (*Complete when the waiver offers the budget authority opportunity as indicated in Item E-1-b*)

- i. Participant Decision Making Authority.** When the participant has budget authority, indicate the decision-making authority that the participant may exercise over the budget. *Check all that apply:*

<input checked="" type="checkbox"/>	Reallocate funds among services included in the budget with prior approval of the PIHP
<input checked="" type="checkbox"/>	Determine the amount paid for services within the State's established limits
<input checked="" type="checkbox"/>	Substitute service providers
<input checked="" type="checkbox"/>	Schedule the provision of services
<input checked="" type="checkbox"/>	Specify additional service provider qualifications consistent with the qualifications specified in Appendix C-3
<input checked="" type="checkbox"/>	Specify how services are provided, consistent with the service specifications contained in Appendix C-3
<input checked="" type="checkbox"/>	Identify service providers and refer for provider enrollment
<input checked="" type="checkbox"/>	Authorize payment for waiver goods and services
<input checked="" type="checkbox"/>	Review and approve provider invoices for services rendered
<input type="checkbox"/>	Other (<i>specify</i>):

- ii. Participant-Directed Budget.** Describe in detail the method(s) that are used to establish the amount of the participant-directed budget for waiver goods and services over which the participant has authority, including how the method makes use of reliable cost estimating information and is applied consistently to each participant. Information about these method(s) must be made publicly available.

Each Participant in this Waiver has an Individual Budget. The Budgeting methodology is described in Appendix C-4. Participants have the authority to request and have approved services that meet the participant's needs within that budget. They may request budget modifications based on new or one time needs as described in the Individual Budgeting Methodology. In addition the Employer or Managing Employer may set aside up to \$2000 per year to purchase Individual Goods and Services. Individual Budget Modifications require the prior approval of the PIHP. Information about the Individual and Family Directed Budget is provided in the Employer Handbook and in additional Handouts provided during Individual and Family Directed Supports Training.

The Participant Directed Budget is known as the Individual and Family Directed Supports Budget and is a component of the Individual Budget. It consists of the total dollar amount of Individual and Family Directed Services at the Individual and Family Directed Supports Rate.

In the Employer of Record Model, the Individual and Family Directed Services Rates are set by the PIHP and is the established hourly service rate for provider directed services rates minus an administrative rate established to cover the costs of Financial Support services, forms and supplies provided to Employers of Record and start-up costs for Employers (blood-borne pathogen supplies, first aid kits, employment ads, background checks, initial employee training, etc.). The Employer is provided with an auto-calculator that assists in managing the Individual and Family Directed Budget. The Employer has the authority to establish employee pay rates and benefits. Additionally, the Employer budgets and directs payment for workers compensation insurance, employment taxes, additional employee training, habilitation training supplies, back-up staffing, and other items that are directly related to the cost of providing services. The Community Guide trains the Employer in the use of the Auto-Calculator and provides alternative methods for budgeting if the Employer does not have access to a computer. The Financial Supports agency establishes procedures for managing participant funds and provides the Employer of Record with a monthly report of revenues (service billing) and expenditures (services provided). The procedures and format for the monthly report are subject to the approval of the PIHP.

In the Agency with Choice Model, the established hourly service rate is the same as the rate paid to the Provider Agency to deliver Innovations waiver services. The service rate includes the cost of employee pay rates, employment taxes, workers compensation insurance, employee benefits, forms, supplies, start-up costs to include first aid kits, employment ads, initial and on-going employee training, criminal and other background checks, first aid supplies, employment ads, habilitation training supplies, qualified professional oversight, maintenance of records, back-up staffing, and other items directly related to the cost of providing services. The Agency with Choice establishes procedures for managing participant funds and assists Managing Employers in budgeting the Individual and Family Directed Budget. The Agency with Choice also provides a monthly report of revenue (service billing) and expenditures to the Managing Employer. The procedures and format for the monthly report are subject to the approval of the PIHP.

- iii. **Informing Participant of Budget Amount.** Describe how the State informs each participant of the amount of the participant-directed budget and the procedures by which the participant may request an adjustment in the budget amount.

The participant, employer, and/or Managing Employer are informed of the participant-directed (Individual and Family Directed) budget amount by the Support Coordinator. A budget adjustment may be requested at any time by directing the Support Coordinator to prepare an Individual Support Plan revision that includes the reason for the need for the adjustment. The Support Coordinator has a standard form that is used in requesting budget adjustments that is attached to the Plan revision.

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iv. Participant Exercise of Budget Flexibility. *Select one:*

<input type="radio"/>	The participant has the authority to modify the services included in the participant-directed budget without prior approval. Specify how changes in the participant-directed budget are documented, including updating the service plan. When prior review of changes is required in certain circumstances, describe the circumstances and specify the entity that reviews the proposed change:
<input checked="" type="radio"/>	Modifications to the participant-directed budget must be preceded by a change in the service plan.

v. Expenditure Safeguards. Describe the safeguards that have been established for the timely prevention of the premature depletion of the participant-directed budget or to address potential service delivery problems that may be associated with budget underutilization and the entity (or entities) responsible for implementing these safeguards:

The Financial Supports Agency and Agency with Choice track the Individual and Family Directed Supports Budget per a standard reporting format developed with and approved by the PIHP. The report is completed monthly and is provided to the Employer or Agency with Choice, the PIHP and Support Coordinator. “Red Flags” that are indicators of potential problems in revenues (under utilization) or spending (over utilization) are identified. The Financial Supports Agency, or any other entity that receives the report, are alert to these red flags so that the Support Coordinator and/or PIHP may address the issue immediately with the employer or Managing Employer. The Employer or Managing Employer may be required to develop a corrective action plan. Continued under or over utilization of the budget may result in removal from Individual and Family Directed Supports and a return to Agency Directed Supports.

Appendix F: Participant Rights

Appendix F-1: Opportunity to Request a Fair Hearing

The State provides an opportunity to request a Fair Hearing under 42 CFR Part 431, Subpart E to individuals: (a) who are not given the choice of home and community-based services as an alternative to the institutional care specified in Item 1-F of the request; (b) are denied the service(s) of their choice or the provider(s) of their choice; or, (c) whose services are denied, suspended, reduced or terminated. The State provides notice of action as required in 42 CFR §431.210.

Procedures for Offering Opportunity to Request a Fair Hearing: Describe how the individual (or his/her legal representative) is informed of the opportunity to request a fair hearing under 42 CFR Part 431, Subpart E. Specify the notice(s) that are used to offer individuals the opportunity to request a Fair Hearing. State laws, regulations, policies and notices referenced in the description are available to CMS upon request through the operating or Medicaid agency.

Innovations operates concurrently with a 1915(b) waiver through a prepaid inpatient health plan (PIHP). All waiver applicants/participants are notified of their right to request a fair hearing by the PIHP in accordance with 42 CFR 431 Subpart E and 42 CFR 438 Subpart F. Participants are required to access the PIHP's internal appeal process before requesting a hearing with the State.

Upon enrollment in the PIHP, the PIHP sends each enrollee a brochure explaining Medicaid appeal rights. For participants with limited literacy, the Support Coordinator (case manager) verbally explains their appeal rights. When applicants/participants are denied participation in the waiver or specific waiver services are denied, terminated, suspended or reduced, the PIHP sends a written notice to the individual explaining the reason for the adverse action, instructions on how to access a fair hearing, the time frame for making the request, information on continuation of services during the appeal process (if applicable) and contact information for questions and concerns. The notice also contains information on the State level hearing processes and toll free numbers for the Medicaid agency and for requesting free legal assistance. Notices of termination, suspension or reduction are mailed to the participant a minimum of 10 days before the service is actually reduced, terminated or suspended.

As stated above, applicants/participants must avail themselves of the grievance process offered by the PIHP before accessing the state fair hearing process. This requirement can be found in the concurrent 1915(b) waiver (#NC 02.RO1), subsection 3a of section E, "Grievance System". If the applicant/participant requests a hearing, the PIHP gathers information on the case and schedules the appeal with an independent reviewer who had no prior involvement in making the adverse decision. The PIHP sends a written notice of the reconsideration decision to the individual along with detailed instructions on requesting a hearing with the State. Applicants/participants may then request an informal appeal with the North Carolina Department of Health and Human Services and/or a formal appeal with the North Carolina Office of Administrative Hearings (OAH).

If the individual requests an informal hearing with DHHS, the DHHS hearings office sends a written notice of the decision including instructions on how to access a formal hearing with the Office of Administrative Hearings and notification of the right to further appeal to Superior Court.

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When the suspension, reduction or termination of service is appealed, participants may continue to receive services up through the final decision by the Office of Administrative Hearings as long as they meet the appeal deadlines, the original period covered by the authorization has not expired, and the participant requests continuation of the service.

Copies of all notices and documentation of decisions are maintained by the agency from which they originate. The PIHP maintains records on the local reconsideration, the DHHS Hearings Office maintains records on the informal hearing, and the Office of Administrative Hearings maintains records on the formal hearing.

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Appendix F-2: Additional Dispute Resolution Process

- a. **Availability of Additional Dispute Resolution Process.** Indicate whether the State operates another dispute resolution process that offers participants the opportunity to appeal decisions that adversely affect their services while preserving their right to a Fair Hearing. *Select one:*

<input checked="checked" type="radio"/>	Yes. The State operates an additional dispute resolution process (<i>complete Item b</i>)
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete Item b</i>)

- b. **Description of Additional Dispute Resolution Process.** Describe the additional dispute resolution process, including: (a) the State agency that operates the process; (b) the nature of the process (i.e., procedures and timeframes), including the types of disputes addressed through the process; and, (c) how the right to a Medicaid Fair Hearing is preserved when a participant elects to make use of the process: State laws, regulations, and policies referenced in the description are available to CMS upon request through the operating or Medicaid agency.

The PIHP has an internal dispute resolution system as required by 42 CFR 438 Subpart F. The internal system encompasses both an appeal process, as described in Appendix F-1, for addressing an “action” and a grievance process for addressing grievances (complaints). “Actions” include the denial or limited authorization of a requested service; reduction, suspension or termination of a previously authorized service; denial of payment for a service; failure to provide services in a timely manner as specified in the risk contract; and failure to take action within the timeframes specified in the contract for resolving grievances and appeals.

A grievance (complaint) is an enrollee’s expression of dissatisfaction with any aspect of their care other than the appeal of an action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the enrollee’s rights

The requirements for the PIHP’s internal appeal and grievance processes are outlined in Section 6 and Attachment P of the PIHP contract. The requirements cover the types of information that the PIHP must provide to enrollees about grievances and appeals; provision of assistance to enrollees in completing necessary forms; reporting and record-keeping; content of notices; expedited authorization decisions; continuation of benefits during appeals; and timeframes for addressing grievances and appeals.

The PIHP provides quarterly reports to the State Medicaid Agency on the types, number and resolution status of grievances and appeals. Tracking and analysis of grievances and appeals are to be used for internal quality improvement.

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Appendix F-3: State Grievance/Complaint System

a. Operation of Grievance/Complaint System. *Select one:*

<input checked="" type="radio"/>	Yes. The State operates a grievance/complaint system that affords participants the opportunity to register grievances or complaints concerning the provision of services under this waiver (<i>complete the remaining items</i>).
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete the remaining items</i>)

b. Operational Responsibility. Specify the State agency that is responsible for the operation of the grievance/complaint system:

DMH/DD/SAS

c. Description of System. Describe the grievance/complaint system, including: (a) the types of grievances/complaints that participants may register; (b) the process and timelines for addressing grievances/complaints; and, (c) the mechanisms that are used to resolve grievances/complaints. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DMH/DD/SAS Rule 10A NCAC 27G.0609 requires the PIHP to report to DMH/DD/SAS all complaints made to the PIHP not less than quarterly. The submission of the LME Complaint Report is included in the contract between the PIHP and DHHS. Four documents provide procedures and instructions relative to the complaint process:

Guidelines for the LME Complaint Reporting System

**Customer Service Collection Form
LME Quarterly Complaint Report
Complaint Reporting Instructions**

A copy of the PIHP's Quarterly Complaint Report is shared with the PIHP Client Rights Committee and the PIHP Consumer and Family Advisory Committee in order to develop strategies for system improvement.

Guidelines require the documentation of any concern, complaint, compliment, investigation, and request for information involving any person requesting or receiving publicly-funded mental health, developmental disabilities and/or substance abuse services, local management entity or MH/DD/SAS service provider.

Complaint Reporting Categories include:

- (1) Abuse, Neglect and Exploitation;**
- (2) Access to Services;**
- (3) Administrative Issues;**
- (4) Authorization/Payment/Billing;**
- (5) Basic Needs;**
- (6) Client Rights;**
- (7) Confidentiality/HIPAA;**
- (8) LME Services;**
- (9) Medication;**
- (10) Provider Choice;**
- (11) Quality of Care;**
- (12) Service Coordination Between Providers; and**

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(13) Other to include any complaint that does not fit the previous areas.

Information is recorded on the Customer Service Form and recorded in the PIHP Complaint Data Base for analysis. Action taken by the PIHP is recorded to include a summary of all issues, investigations and actions taken and the final disposition resolution. Guidelines define the resolution for types of complaints that may be made. The total number of calendar and working days from receipt to completion are also recorded.

If the complainant is not satisfied with the initial resolution, he or she may request to appeal the decision.

The Quarterly Complaint Reporting Form includes the aggregate information on complaints to include:

- (1) The total number of complaints received by the Customer Service Office,
- (2) The total number of persons (by category) who are reporting complaints,
- (3) The total number of consumers by age group,
- (4) The total number of consumers by disability group (if applicable) involved in the complaint,
- (5) The primary nature of the complaints/concerns (by category),
- (6) A summary of data analyses to identify patterns, strategies developed to address problems and actions taken and,
- (7) An evaluation of results of actions taken and recommendations for next steps.

As stated in Appendix F-2 above, grievances (complaints) are also reported to the State Medicaid agency on a quarterly basis as required by the risk contract with the PIHP. The State Medicaid Agency and the DMH/DD/SAS are currently working together with the PIHP to streamline reporting and increase consistency of processes to the extent possible.

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Appendix G: Participant Safeguards

Appendix G-1: Response to Critical Events or Incidents

- a. **Critical Event or Incident Reporting and Management Process.** Indicate whether the State operates Critical Event or Incident Reporting and Management Process that enables the State to collect information on sentinel events occurring in the waiver program. *Select one:*

<input checked="" type="radio"/>	Yes. The State operates a Critical Event or Incident Reporting and Management Process (<i>complete Items b through e</i>)
<input type="radio"/>	No. This Appendix does not apply (<i>do not complete Items b through e</i>). <i>If the State does not operate a Critical Event or Incident Reporting and Management Process, describe the process that the State uses to elicit information on the health and welfare of individuals served through the program.</i>

- b. **State Critical Event or Incident Reporting Requirements.** Specify the types of critical events or incidents (including alleged abuse, neglect and exploitation) that the State requires to be reported for review and follow-up action by an appropriate authority, the individuals and/or entities that are required to report such events and incidents, and the timelines for reporting. State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The DHHS Incident and Death Response System Guidelines describes who must report the documentation required, what/when/where reports must be filed, and the levels of incidents, including responses to each level of incidents. Applicable Laws and Rules include: North Carolina Statute G.S. 122C and Client Rights Rules, APSM 95-2.

Critical Incidents are defined as any happening which is not consistent with routine operation of a facility or service in the routine care of consumers and that is likely to lead to adverse effects upon the consumer. Any incidents containing allegations or substantiations of abuse, neglect, or exploitation must be immediately reported to the local Department of Social Services responsible for investigation of abuse, neglect, or exploitation allegations. Other reports may be required by law, such as reports to law enforcement. Facts regarding the incident should be reported objectively, in writing, without unsubstantiated conclusions, opinions, or accusations. Incident Reports are maintained in administrative files; however, incidents that have an effect on the participant must be recorded in the progress note of the participant record, as would any other consumer care information. Incident reports, including follow-up action requirements, are defined as one of three levels.

Level I Incidents are reported to the PIHP on the PIHP Incident Reporting Form, or a form developed by the provider agency that contains required state elements. Level I incidents are defined as any incident that does not meet the requirements to be classified as a Level II or Level III incident. Examples of Level I incidents include, but are not limited to: consumer injury that does not require treatment by a licensed health care professional; employee and

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visitor injuries; property damage to include all accidents in vehicles, and HIPAA/confidentiality violations. Level I incident reports are reviewed by the employee's supervisor, Managing Employer or Employer of Record and are submitted to a designated person, per agency policy, or maintained in the administrative files of the Employer of Record. The PIHP also requires that Level 1 Incidents for Innovations participants include reporting of failure to provide backup staffing, A Quarterly report summarizing Level I Incidents is submitted to the PIHP, who in turns submits a Quarterly Report to DMH/DD/SAS, an agency within DHHS.

Level II Incidents include any incident that involves a threat to a consumer's health or safety or a threat to the health and safety of others due to consumer behavior. Level II Incidents are reported immediately to the employee's supervisor, Employer of Record, or Managing Employer. The Managing Employer immediately notifies the Agency with Choice.. A written report is prepared that is submitted to and reviewed by the employee's supervisor, Employer of Record, or Managing Employer. The Managing Employer forwards the report to the Agency with Choice. The written report is forwarded to the PIHP within 72 hours of the incident's occurrence.

Level III Incidents include any incident that results in a death or permanent physical or psychological impairment to a consumer; a death or permanent physical or psychological impairment caused by a consumer; or a threat to public safety caused by a consumer. Level III incidents are reported immediately to the employee's supervisor, Employer of Record, or Managing Employer. The Managing Employer immediately notifies the Agency with Choice. The supervisor (including the Financial Support Service provider in the Agency with Choice Model), or Employer of Record immediately notifies the PIHP who notifies DMH/DD/SAS. The PIHP coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared that is submitted to and reviewed by the employee's supervisor (including the Agency with Choice) or Employer of Record. The written report is forwarded to the PIHP within 72 hours of the incident's occurrence. All providers (including the Agency with Choice) and Employers of Record are required to conduct a peer review of Level III incidents beginning within 24 hours of the incident.

- c. **Participant Training and Education.** Describe how training and/or information is provided to participants (and/or families or legal representatives, as appropriate) concerning protections from abuse, neglect, and exploitation, including how participants (and/or families or legal representatives, as appropriate) can notify appropriate authorities or entities when the participant may have experienced abuse, neglect or exploitation.

At the time of entry into the PIHP, participants are provided a Consumer and Family Member Handbook that outlines their rights, protections, and the advocacy agencies who can educate and assist in the event of a concern. The Support Coordinator discusses the rights and protections inclusive of agencies to contact with the participant/legally responsible person as a component of the admissions process to the Innovations waiver. Opportunities for information training occur during routine monitoring.

Providers within the PIHP Network are required to inform the participant of rights and protections through individual agency procedure. When a participant elects the Individual/Family Directed Supports Option, Employers, Managing Employers,

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Representatives and/or Managing Employers receive the Employer Handbook that details their rights, protections and agencies available to assist them in a self-directed services model. The PIHP and the NC Department of Health and Human Services operate toll free care lines where participants can receive additional information or assistance, if needed. These lines have the capacity to assist participants that are primarily Spanish speaking and hearing impaired.

- d. **Responsibility for Review of and Response to Critical Events or Incidents.** Specify the entity (or entities) that receives reports of critical events or incidents specified in item G-1-a, the methods that are employed to evaluate such reports, and the processes and time-frames for responding to critical events or incidents, including conducting investigations.

Incident Reporting requirements and responses are based on state laws and regulations for each of the three levels of incidents.

Level 1 Incidents are maintained by the Provider Agency (including the Agency with Choice) and Employer of Record. Each provider agency (including the Agency with Choice) or Employer of Record is required to submit a Quarterly Report of Level I incidents to the PIHP. Aggregate information on Level I incidents, medication errors, and searches/seizures includes:

- (1) Total number of incidents;**
- (2) Total number of consumers who were involved;**
- (3) Average number of incidents per consumer;**
- (4) Highest number of incidents for any one consumer;**
- (5) Patterns and/or trends found in internal Quality Improvement process; and**
- (6) How problems found are being addressed.**

The PIHP also requires that Level 1 Incidents for Innovations participants include reporting of failure to provide backup staffing,

The PIHP submits a Report of Level I Incident Reports to DMH/DD/SAS, an agency within DHHS, quarterly. In addition, the PIHP reviews a sample of documented responses as part of local monitoring. The PIHP also analyzes trends and patterns in Level I medication errors, searches and seizures, and restrictive interventions as part of Quality Improvement and monitoring planning processes.

Written reports of Level II incidents are forwarded to the PIHP within 72 hours of the incident's occurrence. The provider agency (including the Agency with Choice) and Employer of Record are responsible for attending to the health and safety of involved parties as well as analyzing causes, correcting problems and review in Quality Improvement process to prevent similar incidents. Level II incidents may signal a need for the PIHP to review the provider's clinical care and practices and the PIHP's management processes, including service coordination, service oversight, and technical assistance for providers. These incidents require communication between the provider and the PIHP, documentation of the incident, and report to the PIHP and other authorities as required by law. The PIHP is responsible for reviewing provider handling of the incident and ensuring consumer safety.

Level III Incident are immediately reported to the PIHP who notifies DMH/DD/SAS. The PIHP coordinates all activities required by state standards related to Level III incidents within 24 hours of being informed of the Level III incident. A written report is prepared and reviewed by the agency or Employer submitting the incident. The written report is forwarded

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to the PIHP within 72 hours of the incident's occurrence. Providers (including the Agency with Choice) and Employers of Record attend to the health and safety needs of involved parties, and conduct a peer review of Level III incidents beginning within 24 hours of the incident. The Internal Review:

- (1) Ensures the safety of all concerned;
- (2) Takes action to prevent a reoccurrence of the incident;
- (3) Creates and secures a certified copy of the consumer record;
- (4) Ensures that necessary authorities and persons are notified within allowed timeframes; and
- (5) Conducts a root cause analysis once all needed information is received.

Level III incidents signal a need for DHHS, including the Division of DMH/DD/SAS, and the PIHP to review the local and state service provision and management system, including coordination, technical assistance and oversight. These incidents require communication among the provider, the PIHP, and DHHS, documentation of the incident, and report to the PIHP, DHHS and other authorities as required by law. The PIHP reviews provider handling of the Level III incident:

- (1) To ensure that consumers are safe,
- (2) A certified copy of the participant record is secured;
- (3) A review committee meeting is convened, and
- (4) Appropriate agencies are informed.

DMH/DD/SAS reviews the PIHP oversight of providers and follows up as warranted to ensure problems are corrected.

The PIHP also analyzes and responds to patterns of incidents as part of Quality Improvement and monitoring processes. The PIHP reports aggregate information, trends, and actions taken to DMH/DD/SAS quarterly. DMH/DD/SAS analyzes and responds to statewide patterns of incidents as part of Quality Improvement and monitoring. DMH/DD/SAS also produces statewide incident trend reports quarterly.

Other agency responsibilities for follow-up of Incidents are:

- (1) Local law enforcement agencies investigate legal infractions and take appropriate actions;
- (2) Local Department of Social Services investigates abuse, neglect, or exploitation allegations and take appropriate actions;
- (3) The Health Service Regulation Division of DHHS investigates licensure infractions and take appropriate actions;
- (4) The Health Care Personnel Registry Section of the Health Services Regulation Division investigates personnel infractions and takes appropriate actions; and
- (5) The Governor's Advocacy Council for Persons with Disabilities analyzes trends and advocates as warranted.

A summary of incident reporting and follow-up actions is included in the PIHP'S reporting to DMA.

- e. **Responsibility for Oversight of Critical Incidents and Events.** Identify the State agency (or agencies) responsible for overseeing the reporting of and response to critical incidents or events that affect waiver participants, how this oversight is conducted, and how frequently.

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The DHHS Division of MH/DD/SAS provides oversight and response to critical incidents. The oversight and frequency depends on the level of incident. State responses to critical incidences are described in item d above and in the DHHS incident and death response system guidelines.

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Appendix G-2: Safeguards Concerning Restraints and Restrictive Interventions

a. Use of Restraints or Seclusion (*select one*):

<input type="radio"/>	The State does not permit or prohibits the use of restraints or seclusion. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restraints or seclusion and how this oversight is conducted and its frequency:
<input checked="" type="radio"/>	The use of restraints or seclusion is permitted during the course of the delivery of waiver services. Complete Items G-2-a-i and G-2-a-ii:

i. Safeguards Concerning the Use of Restraints or Seclusion. Specify the safeguards that the State has established concerning the use of each type of restraint (i.e., personal restraints, drugs used as restraints, mechanical restraints or seclusion). State laws, regulations, and policies that are referenced are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

DMH/DD/SAS Rule 10A NCAC 27E.0107 addresses Training on Alternatives to Restrictive Interventions.

Facilities, including provider agencies and Agencies with Choice, must implement policies and procedures that emphasize the use of alternatives to restrictive interventions. Prior to providing services to participants, staff must demonstrate competence by successfully completing training in communication skills and other strategies for creating an environment in which the likelihood of imminent danger of abuse or injury to a person with disabilities or others or property damage is prevented. Agencies must establish training based on state competencies, monitor for internal compliance and demonstrate that they acted on the data gathered. Formal refresher training must occur at least annually. The specific competencies, instructor qualifications, and other training requirements are included in the rule.

Employers of Record are required to provide or arrange for employee training on alternative to restrictive interventions.

DMH/DD/SAS Rule 10A NCAC 27E.0108 addresses Training in Seclusion, Physical Restraint and Isolation Time Out.

Seclusion, physical restraint, and isolation time out may be employed only by staff that have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Staff authorized to employ and terminate these procedures are retrained and demonstrate competency at least annually. This training must occur prior to the provision of direct service to any participant whose Individual Support Plan includes restrictive interventions. Instructor qualifications and training course content regulations are included in the rule.

Restrictive Interventions are reported via the Incident Reporting Regulations. The

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DHHS Restrictive Intervention Details Report is completed along with the Incident Report.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for overseeing the use of restraints or seclusion and ensuring that State safeguards concerning their use are followed and how such oversight is conducted and its frequency:

State agencies and the PIHP are regularly informed on the use of restraints, restrictive interventions and rights restrictions through incident reporting and data reports. State Agencies require the PIHP to report quarterly data from the incident reports given to the PIHP. State agencies review the use of restraints, restrictive interventions and rights restrictions if complaints are made to the state advocacy and consumer affairs office. Any significant injuries which result from employment of a restraint, restrictive intervention or rights restriction must be carefully analyzed and immediately reported to State Agencies and the PIHP.

b. Use of Restrictive Interventions

<input type="radio"/>	The State does not permit or prohibits the use of restrictive interventions. Specify the State agency (or agencies) responsible for detecting the unauthorized use of restrictive interventions and how this oversight is conducted and its frequency:
<input checked="" type="radio"/>	The use of restrictive interventions is permitted during the course of the delivery of waiver services. Complete Items G-2-b-i and G-2-a-ii:

- i. **Safeguards Concerning the Use of Restrictive Interventions.** Specify the safeguards that the State has in effect concerning the use of interventions that restrict participant movement, participant access to other individuals, locations or activities, restrict participant rights or employ aversive methods (not including restraints or seclusion) to modify behavior. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency.

The state requires Provider agencies to maintain Intervention Advisory or Client Rights Committees to provide oversight and periodic reviews of all restraints, restrictive interventions and rights restrictions. Provider agencies are required to analyze data at an aggregate and consumer level to provide to the Intervention Advisory or Client Rights Committees. The Provider Agencies' Intervention Advisory or Client Rights Committee reviews the information for patterns and trends as well as give approval on behavior modification measures implemented on a planned or unplanned basis. These reports must be made available to the PIHP or state agencies as requested.

- ii. **State Oversight Responsibility.** Specify the State agency (or agencies) responsible for monitoring and overseeing the use of restrictive interventions and how this oversight is conducted and its frequency:

Reports are generated to state agencies quarterly by the PIHP. Provider agencies are required to report to the PIHP quarterly.

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Appendix G-3: Medication Management and Administration

This Appendix must be completed when waiver services are furnished to participants who are served in licensed or unlicensed living arrangements where a provider has round-the-clock responsibility for the health and welfare of residents. The Appendix does not need to be completed when waiver participants are served exclusively in their own personal residences or in the home of a family member.

a. Applicability. Select one:

<input checked="" type="radio"/>	Yes. This Appendix applies (<i>complete the remaining items</i>).
<input type="radio"/>	No. This Appendix is not applicable (<i>do not complete the remaining items</i>).

b. Medication Management and Follow-Up

- i. Responsibility.** Specify the entity (or entities) that have ongoing responsibility for monitoring participant medication regimens, the methods for conducting monitoring, and the frequency of monitoring.

Provider agencies, including Agencies with Choice, are required to have a pharmacist or physician complete quarterly medication/ drug reviews for consumers taking medications with potentially serious side effects. The results of the review are reviewed by the PIHP during on-site monitoring visits with the provider agency. Employers of Record are required to train or arrange for training of their employees in medication administration if applicable.

- ii. Methods of State Oversight and Follow-Up.** Describe: (a) the method(s) that the State uses to ensure that participant medications are managed appropriately, including: (a) the identification of potentially harmful practices (e.g., the concurrent use of contraindicated medications); (b) the method(s) for following up on potentially harmful practices; and, (c) the State agency (or agencies) that is responsible for follow-up and oversight.

State rules and regulations outline requirements for policies and procedural precautions which must be implemented for medication management which includes prohibited practices. Provider agencies are required to have a pharmacist or physician complete quarterly medication/ drug reviews for consumers taking medications with potentially serious side effects. The results of the review are reviewed by the state regulatory entities during annual or complaint reviews as part of the state on-site monitoring visits with the provider agency.

c. Medication Administration by Waiver Providers

- i. Provider Administration of Medications.** *Select one:*

<input checked="" type="radio"/>	Waiver providers are responsible for the administration of medications to waiver participants who cannot self-administer and/or have responsibility to oversee participant self-administration of medications. (<i>complete the remaining items</i>)
<input type="radio"/>	Not applicable (<i>do not complete the remaining items</i>)

- ii. State Policy.** Summarize the State policies that apply to the administration of medications by waiver providers or waiver provider responsibilities when participants self-administer medications, including (if applicable) policies concerning medication administration by non-medical waiver provider personnel. State laws, regulations, and policies referenced in the specification are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

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State rules and regulations outline requirements for policies and procedures to be implemented for medication administration including self-medication. Consumers who self-medicate are required to have an assessment on their ability to self-medicate and a physician must sign an order for self-medication. Documentation must be maintained as outlined in state rules/regulations.

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iii. Medication Error Reporting. *Select one of the following:*

<input checked="" type="radio"/>	Providers that are responsible for medication administration are required to <i>both</i> record and report medication errors to a State agency (or agencies). <i>Complete the following three items:</i>
	(a) Specify State agency (or agencies) to which errors are reported: Provider Agencies, Agencies with Choice and Employers of Record report medication errors to the PIHP who in turn reports the errors to the Division of MH/DD/SAS through Incident Reporting described in Appendix G-1.
	(b) Specify the types of medication errors that providers are required to <i>record</i> : Errors reported include: wrong or missed dosage; wrong medication; wrong time (over 1 hour from prescribed time); or medication refusals by the participant
	(c) Specify the types of medication errors that providers must <i>report</i> to the State: Any error that results in permanent physical or psychological impairment is reported to the Division of MH/DD/SAS via Level III Incident Reporting. Any error that does not threaten the individual's health and safety, as determined by a physician or pharmacist notified of the error is reported via Level I Incident Reporting.
<input type="radio"/>	Providers responsible for medication administration are required to <i>record</i> medication errors but make information about medication errors available only when requested by the State. Specify the types of medication errors that providers are required to record:

iv. State Oversight Responsibility. Specify the State agency (or agencies) responsible for monitoring the performance of waiver providers in the administration of medications to waiver participants and how monitoring is performed and its frequency.

The PIHP reports medication errors via Incident Reporting described in Appendix G-1. This includes Quarterly Reporting to the Division of DMH/DD/SAS.

Quality Management: Health and Welfare

As a distinct component of the State's quality management strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery:

a.i *There is continuous monitoring of the health and welfare of waiver participants and remediation actions are initiated when appropriate.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance complete the following. Where possible, include numerator/denominator.

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Performance Measure:	Proportion of waiver participants whose health and welfare is monitored according to the waiver process and Support Coordinator Monitoring Tool		
Data Source Record Reviews on site On site monitoring Analyze collected data	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input type="checkbox"/> Other: Specify: Semi-Annually	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

Performance Measure:	Proportion of waiver participants for whom health and welfare issues are discovered and appropriate remediation took place		
Data Source Incident Reporting Record Review on site On site monitoring Mortality Reviews Analyze Collected Data	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Representative

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			<i>Sample</i>
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input type="checkbox"/> Other: Specify:	
			<input type="checkbox"/> Other: Describe
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

Add another Data Source for this performance measure

- a.ii If applicable, in the textbox below provides any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.

N/A

b. Methods for Remediation

- b.i Describe the States strategy for addressing individual problems as they are discovered.

The PIHP will analyze and address problems identified and include the analysis in the report to DMA and the Intra-Departmental monitoring team. DMA will require corrective action plans as needed. The PIHP develops corrective action plans that are submitted and approved by DMA. As corrective action is completed the PIHP reports to DMA who monitors the action until the corrective action is completed.

DMA requires the PIHP to contact DMA immediately about any issue that has or may have a significant negative impact on participant health and welfare. DMA and the PIHP work together to resolve such issues as they occur.

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b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

N/A

Appendix H: Quality Management Strategy

Under §1915(c) of the Social Security Act and 42 CFR §441.302, the approval of an HCBS waiver requires that CMS determine that the State has made satisfactory assurances concerning the protection of participant health and welfare, financial accountability and other elements of waiver operations. Renewal of an existing waiver is contingent upon review by CMS and a finding by CMS that the assurances have been met. By completing the HCBS waiver application, the State specifies how it has designed the waiver's critical processes, structures and operational features in order to meet these assurances.

- Quality Management is a critical operational feature that an organization employs to continually determine whether it operates in accordance with the approved design of its program, meets statutory and regulatory assurances and requirements, achieves desired outcomes, and identifies opportunities for improvement.

CMS recognizes that a state's waiver Quality Management Strategy may vary depending on the nature of the waiver target population, the services offered, and the waiver's relationship to other public programs, and will extend beyond regulatory requirements. However, for the purpose of this application, the State is expected to have, at the minimum, systems in place to measure and improve its own performance in meeting six specific waiver assurances and requirements.

It may be more efficient and effective for a Quality Management Strategy to span multiple waivers and other long-term care services. CMS recognizes the value of this approach and will ask the state to identify other waiver programs and long-term care services that are addressed in the Quality Management Strategy.

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Quality Management Strategy: Minimum Components

The Quality Management Strategy that will be in effect during the period of the waiver is described throughout the waiver in the appendices corresponding to the statutory assurances and sub-assurances. Other documents that are cited must be available to CMS upon request through the Medicaid agency or the operating agency (if appropriate).

In the QMS discovery and remediation sections throughout the application (located in Appendices A, B, C, D, G, and I), a state spells out:

- The evidence based *discovery* activities that will be conducted for each of the six major waiver assurances;
- The *remediation* processes followed when problems are identified in the implementation of each of the assurances;

In Appendix H of the application, a State describes the *system improvement* processes followed in response to aggregated, analyzed information collected on each of the assurances;

- The correspondent *roles/responsibilities* of those conducting assessing and improving system functions around the assurances; and
- The process that the state will follow to continuously *assess the effectiveness of the QMS* and revise it as necessary and appropriate.

If the State's Quality Management Strategy is not fully developed at the time the waiver application is submitted, the state may provide a work plan to fully develop its Quality Management Strategy, including the specific tasks that the State plans to undertake during the period that the waiver is in effect, the major milestones associated with these tasks, and the entity (or entities) responsible for the completion of these tasks.

When the Quality Management Strategy spans more than one waiver and/or other types of long-term care services under the Medicaid State plan, specify the control numbers for the other waiver programs and identify the other long-term services that are addressed in the Quality Management Strategy. In instances when the QMS spans more than one waiver, the State must be able to provide waiver-specific information.

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H.1 Systems Improvement

- H.1.a.i Describe the process for trending, prioritizing and implementing system improvements (i.e., design changes) prompted as a result of an analysis of discovery and remediation information.

Innovations operates under the umbrella of a 1915(b) waiver, and both State Plan MH/DD/SA services and Innovations services are delivered through a prepaid inpatient health plan (PIHP) under the terms of a risk contract. Each waiver type has distinct requirements for quality management that are based on federal laws and regulations and are meant to ensure that the goals and intent of the respective waivers are met. During the initial waiver period, quality management programs and activities for each waiver were developed and implemented separately. PIHP reporting on performance measures and performance improvement projects, an External Quality Review (EQR) contract, and an Independent Assessment contract were implemented in compliance with managed care regulations and 1915(b) waiver requirements. Quality management activities for the Innovations waiver during the initial waiver period included oversight of the PIHP's implementation of processes and procedures to address 1915(c) waiver assurances, case manager oversight of plan implementation and service delivery, and record reviews to identify any issues related to meeting assurances. As the services and populations covered by both waivers are interrelated and the infrastructure and processes for PIHP oversight are now in place, the goal during the upcoming renewal period is to better integrate quality management activities for all PIHP Medicaid services and to begin to focus on quality improvement. At the same time, it will be necessary to ensure that the specific quality management requirements of each waiver type continue to be met.

As stated above, performance measure reporting related mainly to State Plan MH/DD/SA services through the PIHP has already been implemented. The 1915(c) waiver application contains 18 performance measures specific to the Innovations waiver which will be implemented and reported to the State through similar processes. The PIHP will also revise its reporting on grievances and appeals to identify those made specifically by or on behalf of Innovations participants/applicants. Up until now, the reporting has been disability specific in terms of mental illness, developmental disability and substance abuse needs.

Quarterly quality management meetings with the Division of Medical Assistance (DMA), the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) and the PIHP have been in place since implementation of the waiver program. The meetings have focused a great deal on implementation of the overall concurrent waiver program and activities specific to Medicaid managed care, including reporting requirements, refining of reports, and implementation of External Quality Review activities. This setting provides an excellent backdrop for operationalizing the Innovations performance measures and moving to the next level of trending, analyzing, and setting benchmarks for all services delivered through the PIHP.

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An Intradepartmental Monitoring Team (IMT) which meets with the PIHP quarterly and conducts annual on-site reviews of PIHP operations has been active since the waivers were implemented. Up until now, the IMT has focused heavily on the transition of the PBH local management entity into a fully functional managed care entity with the capabilities for authorizing and managing services, accurate and prompt payment of claims, developing strong utilization and quality management departments, and becoming data driven in its decision making. As of the 2007 IMT on-site review, the State believes that the PIHP has successfully made this transition and, as a result, IMT activities will take on more of a quality improvement rather than an implementation focus in both clinical and non-clinical areas.

The State and the PIHP have implemented corrective action plans based on specific monitoring activities (such as the annual on-site review) and they have been excellent vehicles for bringing about positive system changes. Appendix A of the application describes several discovery activities that the State Medicaid Agency will conduct in exercising its administrative authority over the waiver. All of these activities, including analysis of performance measure reporting, findings from IMT and external reviews, analysis of grievances and appeals reports, record reviews by the PIHP and review of provider network for adequacy and choice, will be the basis for an ongoing corrective action/quality improvement plan. The corrective action/quality improvement plan will be a working document that will identify areas for improvement, progress and target dates for completion. The areas for improvement will be prioritized and monitored on a day-to-day basis by the DMA waiver team and the DMA Behavioral Health section. Progress, issues and concerns will be presented to the IMT, which will serve as an advisory committee for the plan.

Through tracking and trending of performance reporting and findings from other oversight activities, DMA and the PIHP expect to be able to identify any provider-specific and process-specific issues and implement corrective actions that will lead to overall quality improvement. As examples, with trending and tracking of complaints: a specific provider might be identified who needs additional training or even termination from the network; recurring and excessive delays in implementing service plans might result in changes in internal assessment/authorization processes; and, as a final example, inconsistencies identified in level of care determinations could result in additional training to assure that staff have the same understanding of level of care criteria.

Progress on the corrective action/quality improvement plan will be presented quarterly to the IMT for comments and guidance. All Innovations related monitoring will be summarized and presented to CMS annually through the 372 report process and as requested.

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H.1.a.ii

System Improvement Activities	Responsible Party (check each that applies)	Frequency of monitoring and analysis (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly
	<input type="checkbox"/> Case Management Agency	<input checked="" type="checkbox"/> Quarterly (analysis)
	<input type="checkbox"/> Quality Improvement Committee	<input type="checkbox"/> Annually
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input checked="" type="checkbox"/> Other: Specify (monitoring) Ongoing

- H.1.b.i. Describe the process for monitoring and analyzing the effectiveness of system design changes, including a description of the various roles and responsibilities involved in the processes for monitoring & assessing system design changes. If applicable, include the State's targeted standards for systems improvement.

The effectiveness of system design changes - for example, a revised process to initiate the delivery of services more promptly - will be evident through ongoing monitoring activities using the same performance measures. Once performance measures are implemented and the PIHP has an initial baseline year of service experience, the State and the PIHP will jointly develop benchmark priorities. The DMA Behavioral Health and waiver teams and the PIHP QM team will work jointly through the quarterly quality management meetings to assess system changes and begin developing benchmarks. The IMT will serve in an advisory and oversight capacity.

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Appendix I: Financial Accountability

APPENDIX I-1: Financial Integrity and Accountability

Financial Integrity. Describe the methods that are employed to ensure the integrity of payments that have been made for waiver services, including: (a) requirements concerning the independent audit of provider agencies; (b) the financial audit program that the state conducts to ensure the integrity of provider billings for Medicaid payment of waiver services, including the methods, scope and frequency of audits; and, (c) the agency (or agencies) responsible for conducting the financial audit program. State laws, regulations, and policies referenced in the description are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

Innovations operates concurrently with a 1915(b) waiver and all services are provided through a prepaid inpatient health plan (PIHP). In accordance with the risk contract between the State Medicaid agency and the PIHP, the Division of Medical Assistance (DMA) makes a capitated payment monthly to the PIHP for each enrollee and the PIHP provides all needed MH/DD/SA services through its provider network. Section 9.4 of the contract requires the PIHP to implement a compliance plan to guard against fraud and abuse, to conduct provider audits to verify that services authorized and paid for by the PIHP are actually provided, and to take disciplinary action when needed. The PIHP reports any incidents of fraud and abuse to DMA. Provider agencies are monitored at a frequency set by the PIHP but no less than every three years.

Section 6 of the contract also requires that the PIHP's annual financial reports be audited in accordance with Generally Accepted Auditing Standards by an independent Certified Public Accountant. The PIHP provides copies of the annual audit to DMA. The annual financial audit is subject to independent verification and audit by a firm of DMA's choosing.

DMA assures that services are provided to waiver participants appropriately through several required activities described in the contract such as routine financial and clinical reports by the PIHP, administration of consumer and provider surveys by the PIHP or an external entity, on-site reviews of operational processes and procedures, record reviews and external quality review activities through an independent entity.

The entity responsible for conducting the independent audit of the waiver required by the Single Audit Act is the North Carolina Office of the State Auditor.

Quality Management: Financial Accountability

As a distinct component of the State's quality management strategy, provide information in the following fields to detail the State's methods for discovery and remediation.

a. Methods for Discovery:

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- a.i** *Claims for Federal financial participation in the costs of waiver services are based on state payments for waiver services that have been rendered to waiver participants, authorized in the service plan, and properly billed by qualified waiver providers in accordance with the approved waiver.*

For each performance measure/indicator the State will use to assess compliance with the statutory assurance, complete the following. Where possible, include numerator/denominator.

Performance Measure:	Proportion of claims that are billed to the PIHP for Innovations waiver services that are provided as required by the terms of the waiver		
Data Source: Provider record reviews by the PIHP	Responsible Party for data collection/generation (check each that applies)	Frequency of data collection/generation: (check each that applies)	Sampling Approach (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Representative Sample
	<input type="checkbox"/> Operating Agency	<input checked="" type="checkbox"/> Monthly	<input type="checkbox"/> 100% Review
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	<input type="checkbox"/> Stratified: Describe Group
		<input type="checkbox"/> Other: Specify:	
			<input checked="" type="checkbox"/> Other: Describe: Random Sample
Data Aggregation and Analysis	Responsible Party for data aggregation and analysis (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input checked="" type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input checked="" type="checkbox"/> Other: Specify: PIHP	<input type="checkbox"/> Annually	
		<input checked="" type="checkbox"/> Other: Specify: Semi-annually	

- a.ii** *If applicable, in the textbox below provides any necessary additional information on the strategies employed by the State to discover/identify problems/issues within the waiver program, including frequency and parties responsible.*

Medicaid capitated payments to the PIHP are developed and certified by actuarial staff in accordance with managed care requirements for contracts and rate development in 42 CFR Part

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438. The actuaries use PIHP encounter data to set the rates and take into consideration any program or policy changes that might impact the waiver program.

b. Methods for Remediation

b.i Describe the States strategy for addressing individual problems as they are discovered.

The PIHP has the authority to require corrective action plans of its providers and recoup payments when it finds services are provided inappropriately, i.e., services are not provided in accordance with program requirements. The PIHP may require the providers to implement corrective action plans depending on the severity and nature of the problem. When significant problems are detected that may impact the health and safety of consumers, the PIHP reports to the State immediately. The State assists with remediation as appropriate and may require corrective actions by the PIHP.

b.ii Remediation Data Aggregation

Remediation-related Data Aggregation and Analysis (including trend identification)	Responsible Party (check each that applies)	Frequency of data aggregation and analysis: (check each that applies)	Method of Aggregation Reporting: (check each that applies)
	<input checked="" type="checkbox"/> State Medicaid Agency	<input type="checkbox"/> Weekly	<input checked="" type="checkbox"/> Narrative Report
	<input type="checkbox"/> Operating Agency	<input type="checkbox"/> Monthly	<input type="checkbox"/> Data Compilation
	<input type="checkbox"/> Case Management Agency	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Other: Specify
	<input type="checkbox"/> Other: Specify:	<input checked="" type="checkbox"/> Annually	
		<input type="checkbox"/> Other: Specify:	

c. Timelines

The State provides timelines to design or implement methods for discovery and remediation that are currently non-operational.

<input type="radio"/>	Yes (complete remainder of item)
<input checked="" type="radio"/>	No

Please provide the specific strategy to be employed, the timeline for bringing the effort online and the parties responsible for its implementation.

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N/A

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APPENDIX I-2: Rates, Billing and Claims

- a. **Rate Determination Methods.** In two pages or less, describe the methods that are employed to establish provider payment rates for waiver services and the entity or entities that are responsible for rate determination. Indicate any opportunity for public comment in the process. If different methods are employed for various types of services, the description may group services for which the same method is employed. State laws, regulations, and policies referenced in the description are available upon request to CMS through the Medicaid agency or the operating agency (if applicable).

The PIHP, through the PIHP Operations Oversight Team, is responsible for setting all rates for waiver services. The Operations Oversight Team is comprised of the Chief Operating Officer, The Director of Administration, the Director of Clinical Operations and the Chief Medical Officer. The PIHP sets rates based on demand for services, availability of qualified providers, clinical priority or best clinical practices, and estimated provider service cost. The PIHP uses the State's Medicaid rates for similar services as a guide in setting rates.

All proposed changes to existing rates or for implementing new rates are reviewed internally by the PIHP Financial Oversight Cross Functional team and externally by the PIHP Provider Network Advisory Council. The Provider Council is comprised of a cross section of the PIHP provider network. Rate reviews focus on internal and external equity and consistency. Providers are notified of rate changes by announcement at the monthly Provider meeting, in the monthly provider newsletter and on-line posting on the PIHP website.

The PIHP reimburses waiver service providers on a Fee-For-Service basis for most services and for most providers. Exceptions to this are for emergency services, which are provided by sub-capitated providers, and for those services which call for a daily rate or one-time payment.

The PIHP uses the same reimbursement rate for all providers for the same waiver services. For services provided through the Individual Family Directed option (Employer of Record Model), the administrative portion of the service rate is set aside to cover charges for Financial Supports Service, Community Guide and other administrative costs. The direct service portion of the rate is made available to the Employer of Record for wages and benefits.

- b. **Flow of Billings.** Describe the flow of billings for waiver services, specifying whether provider billings flow directly from providers to the State's claims payment system or whether billings are routed through other intermediary entities. If billings flow through other intermediary entities, specify the entities:

The Innovations waiver operates concurrently with a 1915(b) waiver, #NC-02.R01. Capitated payments for each waiver enrollee are made to the PIHP monthly through the State's MMIS in accordance with Section A.I.B of the concurrent 1915(b) waiver, "Delivery Systems," and Section 10 of the risk contract between the State Medicaid agency and the PIHP. The capitated payments are considered payment in full for all services covered under the 1915(b)/1915(c) concurrent waivers.

Individual providers bill the PIHP according to the terms of the contract between the PIHP and its providers. Section 11 of the risk contract between the State Medicaid agency and the

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PIHP outline requirements for subcontracting and timeliness of payment to providers by the PIHP. The PIHP may not contract with a subcontractor who is not eligible for participation in the Medicaid program.

c. Certifying Public Expenditures (*select one*):

<input type="radio"/>	Yes. Public agencies directly expend funds for part or all of the cost of waiver services and certify their public expenditures (CPE) in lieu of billing that amount to Medicaid (<i>check each that applies</i>):
<input type="checkbox"/>	Certified Public Expenditures (CPE) of State Public Agencies. Specify: (a) the public agency or agencies that certify public expenditures for waiver services; (b) how it is assured that the CPE is based on the total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-a.</i>)
<input type="checkbox"/>	Certified Public Expenditures (CPE) of Non-State Public Agencies. Specify: (a) the non-State public agencies that incur certified public expenditures for waiver services; (b) how it is assured that the CPE is based on total computable costs for waiver services; and, (c) how the State verifies that the certified public expenditures are eligible for Federal financial participation in accordance with 42 CFR §433.51(b). (<i>Indicate source of revenue for CPEs in Item I-4-b.</i>)
<input checked="" type="radio"/>	No. Public agencies do not certify expenditures for waiver services.

- d. **Billing Validation Process.** Describe the process for validating provider billings to produce the claim for federal financial participation, including the mechanism(s) to assure that all claims for payment are made only: (a) when the individual was eligible for Medicaid waiver payment on the date of service; (b) when the service was included in the participant's approved service plan; and, (c) the services were provided:

At the State Level:

The State determines eligibility for capitated payments by identifying individuals through the MMIS who, as of a set date at the end of each month: are eligible for Medicaid; reside in one of the counties covered by the waiver; and have a special indicator that signifies participation in an HCBS waiver for individuals meeting the ICF-MR level of care. (The special indicator is entered in the State's Eligibility Information System (EIS) by the local department of social services upon notification from the PIHP that the individual has been approved for waiver participation. Eligibility changes are transmitted to the MMIS on a nightly basis.) The MMIS generates a capitated payment to the PIHP at the beginning of the following month for each waiver participant identified through this process. DMA requires the PIHP to review a random sample of records and encounter data periodically to determine whether assurances as to service plans and service delivery are met and report findings to DMA.

At the PIHP/Local Level:

Eligibility for waiver participation is determined by the PIHP and eligibility for Medicaid is determined by the local department of social services (DSS). The PIHP notifies the DSS when eligibility for waiver participation is authorized, the DSS then enters the special waiver indicator into the Eligibility Information System and the indicator is transmitted to the MMIS. The MMIS generates an enrollment report at the end of each month which identifies waiver participants for whom payment will be made at the beginning of the next month. The PIHP uses this report to verify that waiver eligibility has been entered into the system and to identify any waiver participants who have lost Medicaid eligibility. Regarding payment for waiver services according to the plan of care, authorization for the individual waiver services in the plan is entered into the PIHP's claims payment system which prevents payment for unauthorized services. The PIHP monitors service delivery through case manager contact with waiver participants and billing audits of providers.

- e. **Billing and Claims Record Maintenance Requirement.** Records documenting the audit trail of adjudicated claims (including supporting documentation) are maintained by the Medicaid agency, the operating agency (if applicable), and providers of waiver services for a minimum period of 3 years as required in 45 CFR §74.53.

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APPENDIX I-3: Payment

a. Method of payments — MMIS (*select one*):

<input type="radio"/>	Payments for all waiver services are made through an approved Medicaid Management Information System (MMIS).
<input type="radio"/>	Payments for some, but not all, waiver services are made through an approved MMIS. Specify: (a) the waiver services that are not paid through an approved MMIS; (b) the process for making such payments and the entity that processes payments; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64.
<input type="radio"/>	Payments for waiver services are not made through an approved MMIS. Specify: (a) the process by which payments are made and the entity that processes payments; (b) how and through which system(s) the payments are processed; (c) how an audit trail is maintained for all state and federal funds expended outside the MMIS; and, (d) the basis for the draw of federal funds and claiming of these expenditures on the CMS-64:
<input checked="" type="radio"/>	Payments for waiver services are made by a managed care entity or entities. The managed care entity is paid a monthly capitated payment per eligible enrollee through an approved MMIS. Describe how payments are made to the managed care entity or entities: Eligibility for waiver participation is entered into the State's Eligibility Information System (EIS) by the local departments of social services in the five Piedmont counties once the determination has been made that the individual is Medicaid eligible and the PIHP has notified the social services agency that the individual has been authorized to participate in the waiver. The EIS transmits eligibility to the MMIS which pays a capitated payment to the PIHP monthly for each waiver participant. Capitated payments continue until one of the following occurs: the individual loses Medicaid eligibility; the individual moves to a county outside of the Piedmont catchment area; or the social services agency, upon instruction from the PIHP, removes the individual from the waiver. For waiver participants who have deductibles (spend-downs), the MMIS pays prorated capitated payments based on the date the deductible is met.

b. Direct payment. In addition to providing that the Medicaid agency makes payments directly to providers of waiver services, payments for waiver services are made utilizing one or more of the following arrangements (*select at least one*):

<input type="checkbox"/>	The Medicaid agency makes payments directly and does not use a fiscal agent (comprehensive or limited) or a managed care entity or entities.
<input type="checkbox"/>	The Medicaid agency pays providers through the same fiscal agent used for the rest of the Medicaid program.
<input type="checkbox"/>	The Medicaid agency pays providers of some or all waiver services through the use of a limited fiscal agent. Specify the limited fiscal agent, the waiver services for which the limited fiscal agent makes payment, the functions that the limited fiscal agent performs in paying waiver claims, and the methods by which the Medicaid agency oversees the operations of the limited fiscal agent:

<input checked="" type="checkbox"/>	Providers are paid by a managed care entity or entities for services that are included in the State's contract with the entity. Specify how providers are paid for the services (if any) not included in the State's contract with managed care entities.
	Not Applicable

- c. **Supplemental or Enhanced Payments.** Section 1902(a)(30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a)(1) provides for Federal financial participation to States for expenditures for services under an approved State plan/waiver. Specify whether supplemental or enhanced payments are made. *Select one:*

<input checked="" type="radio"/>	No. The State does not make supplemental or enhanced payments for waiver services.
<input type="radio"/>	Yes. The State makes supplemental or enhanced payments for waiver services. Describe: (a) the nature of the supplemental or enhanced payments that are made and the waiver services for which these payments are made and (b) the types of providers to which such payments are made. Upon request, the State will furnish CMS with detailed information about the total amount of supplemental or enhanced payments to each provider type in the waiver.

- d. **Payments to Public Providers.** *Specify whether public providers receive payment for the provision of waiver services.*

<input type="radio"/>	Yes. Public providers receive payment for waiver services. Specify the types of public providers that receive payment for waiver services and the services that the public providers furnish. <i>Complete item I-3-e.</i>
<input checked="" type="radio"/>	No. Public providers do not receive payment for waiver services. <i>Do not complete Item I-3-e.</i>

- e. **Amount of Payment to Public Providers.** Specify whether any public provider receives payments (including regular and any supplemental payments) that in the aggregate *exceed* its reasonable costs of providing waiver services and, if so, how the State recoups the excess and returns the Federal share of the excess to CMS on the quarterly expenditure report. *Select one:*

<input type="radio"/>	The amount paid to public providers is the same as the amount paid to private providers of the same service.
<input type="radio"/>	The amount paid to public providers differs from the amount paid to private providers of the same service. No public provider receives payments that in the aggregate exceed its reasonable costs of providing waiver services.

Appendix I: Financial Accountability

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○	<p>The amount paid to public providers differs from the amount paid to private providers of the same service. When a public provider receives payments (including regular and any supplemental payments) that in the aggregate exceed the cost of waiver services, the State recoups the excess and returns the federal share of the excess to CMS on the quarterly expenditure report. Describe the recoupment process:</p>
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- f. **Provider Retention of Payments.** Section 1903(a)(1) provides that Federal matching funds are only available for expenditures made by states for services under the approved waiver. *Select one:*

<input type="radio"/>	Providers receive and retain 100 percent of the amount claimed to CMS for waiver services.
<input type="radio"/>	Providers do not receive and retain 100 percent of the amount claimed to CMS for waiver services. Provide a full description of the billing, claims, or payment processes that result in less than 100% reimbursement of providers. Include: (a) the methodology for reduced or returned payments; (b) a complete listing of types of providers, the amount or percentage of payments that are reduced or returned; and, (c) the disposition and use of the funds retained or returned to the State (i.e., general fund, medical services account, etc.):
<input checked="" type="radio"/>	Providers are paid by a managed care entity (or entities) that are paid a monthly capitated payment. Specify whether the monthly capitated payment to managed care entities is reduced or returned in part to the State.
	The PIHP has retained 100% of the monthly capitated payment as of this date. During the initial year of waiver operation, the PIHP generated savings, i.e., the cost of providing both State Plan and waiver services was less than the capitated payments. The 1915(b) waiver was amended and approved by CMS to reinvest all savings in 1915(b)(3) services.

- g. **Additional Payment Arrangements**

- i. **Voluntary Reassignment of Payments to a Governmental Agency.** *Select one:*

<input type="radio"/>	Yes. Providers may voluntarily reassign their right to direct payments to a governmental agency as provided in 42 CFR §447.10(e). Specify the governmental agency (or agencies) to which reassignment may be made.
<input checked="" type="radio"/>	No. The State does not provide that providers may voluntarily reassign their right to direct payments to a governmental agency.

- ii. **Organized Health Care Delivery System.** *Select one:*

<input type="radio"/>	Yes. The waiver provides for the use of Organized Health Care Delivery System arrangements under the provisions of 42 CFR §447.10. Specify the following: (a) the entities that are designated as an OHCDs and how these entities qualify for designation as an OHCDs; (b) the procedures for direct provider enrollment when a provider does not voluntarily agree to contract with a designated OHCDs; (c) the method(s) for assuring that participants have free choice of qualified providers when an OHCDs arrangement is employed, including the selection of providers not affiliated with the OHCDs; (d) the method(s) for assuring that providers that furnish services under contract with an OHCDs meet applicable provider qualifications under the waiver; (e) how it is assured that OHCDs contracts with providers meet applicable requirements; and, (f) how financial accountability is assured when an OHCDs arrangement is used:
<input checked="" type="radio"/>	No. The State does not employ Organized Health Care Delivery System (OHCDs) arrangements under the provisions of 42 CFR §447.10.

iii. Contracts with MCOs, PIHPs or PAHPs. *Select one:*

<input type="radio"/>	The State contracts with a Managed Care Organization(s) (MCOs) and/or prepaid inpatient health plan(s) (PIHP) or prepaid ambulatory health plan(s) (PAHP) under the provisions of §1915(a)(1) of the Act for the delivery of waiver and other services. Participants may <i>voluntarily</i> elect to receive <i>waiver</i> and other services through such MCOs or prepaid health plans. Contracts with these health plans are on file at the State Medicaid agency. Describe: (a) the MCOs and/or health plans that furnish services under the provisions of §1915(a)(1); (b) the geographic areas served by these plans; (c) the waiver and other services furnished by these plans; and, (d) how payments are made to the health plans.
<input checked="" type="radio"/>	This waiver is a part of a concurrent §1915(b)/§1915(c) waiver. Participants are required to obtain <i>waiver</i> and other services through a MCO and/or prepaid inpatient health plan (PIHP) or a prepaid ambulatory health plan (PAHP). The §1915(b) waiver specifies the types of health plans that are used and how payments to these plans are made.
<input type="radio"/>	The State does not contract with MCOs, PIHPs or PAHPs for the provision of waiver services.

APPENDIX I-4: Non-Federal Matching Funds

- a. **State Level Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the State source or sources of the non-federal share of computable waiver costs. *Check each that applies:*

<input checked="" type="checkbox"/>	Appropriation of State Tax Revenues to the State Medicaid agency
<input type="checkbox"/>	Appropriation of State Tax Revenues to a State Agency other than the Medicaid Agency. If the source of the non-federal share is appropriations to another state agency (or agencies), specify: (a) the entity or agency receiving appropriated funds and (b) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if the funds are directly expended by public agencies as CPEs, as indicated in Item I-2-c:
<input type="checkbox"/>	Other State Level Source(s) of Funds. Specify: (a) the source and nature of funds; (b) the entity or agency that receives the funds; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and/or, indicate if funds are directly expended by public agencies as CPEs, as indicated in Item I-2- c:

- b. **Local or Other Source(s) of the Non-Federal Share of Computable Waiver Costs.** Specify the source or sources of the non-federal share of computable waiver costs that are not from state sources. *Check each that applies:*

<input checked="" type="checkbox"/>	Appropriation of Local Revenues. Specify: (a) the local entity or entities that have the authority to levy taxes or other revenues; (b) the source(s) of revenue; and, (c) the mechanism that is used to transfer the funds to the Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement (indicate any intervening entities in the transfer process), and/or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
	Local revenues are allocated through a county's General Fund. Those funds are derived from a variety of sources, most of them being taxes. Funds are transferred electronically from all 100 counties each month.
<input type="checkbox"/>	Other non-State Level Source(s) of Funds. Specify: (a) the source of funds; (b) the entity or agency receiving funds; and, (c) the mechanism that is used to transfer the funds to the State Medicaid Agency or Fiscal Agent, such as an Intergovernmental Transfer (IGT), including any matching arrangement, and /or, indicate if funds are directly expended by public agencies as CPEs, as specified in Item I-2- c:
<input type="checkbox"/>	Not Applicable. There are no non-State level sources of funds for the non-federal share.

- c. Information Concerning Certain Sources of Funds.** Indicate whether any of the funds listed in Items I-4-a or I-4-b that make up the non-federal share of computable waiver costs come from the following sources: (a) provider taxes or fees; (b) provider donations; and/or, (c) federal funds (other than FFP). *Select one:*

<input checked="" type="radio"/>	None of the specified sources of funds contribute to the non-federal share of computable waiver costs.
<input type="radio"/>	The following source (s) is used. <i>Check each that applies.</i>
<input type="checkbox"/>	Provider taxes or fees
<input type="checkbox"/>	Provider donations
<input type="checkbox"/>	Federal funds (other than FFP)
	For each source of funds indicated above, describe the source of the funds in detail:

APPENDIX I-5: Exclusion of Medicaid Payment for Room and Board

a. Services Furnished in Residential Settings. *Select one:*

<input type="radio"/>	No services under this waiver are furnished in residential settings other than the private residence of the individual. <i>(Do not complete Item I-5-b).</i>
<input checked="" type="radio"/>	As specified in Appendix C, the State furnishes waiver services in residential settings other than the personal home of the individual. <i>(Complete Item I-5-b)</i>

b. Method for Excluding the Cost of Room and Board Furnished in Residential Settings. The following describes the methodology that the State uses to exclude Medicaid payment for room and board in residential settings:

The capitated payments to the PIHP were initially based on expenditures for similar services in the fee-for-service MR/DD waiver that serves the rest of the State. Fee-for-service payment rates are based on the cost of providing the service exclusive of room and board. Other funding sources are used by the State and local governments, including the Piedmont counties, to pay for room and board in licensed residential facilities.

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APPENDIX I-6: Payment for Rent and Food Expenses of an Unrelated Live-In Caregiver

Reimbursement for the Rent and Food Expenses of an Unrelated Live-In Personal Caregiver.

Select one:

<input type="radio"/>	<p>Yes. Per 42 CFR §441.310(a)(2)(ii), the State will claim FFP for the additional costs of rent and food that can be reasonably attributed to an unrelated live-in personal caregiver who resides in the same household as the waiver participant. The State describes its coverage of live-in caregiver in Appendix C-3 and the costs attributable to rent and food for the live-in caregiver are reflected separately in the computation of factor D (cost of waiver services) in Appendix J. FFP for rent and food for a live-in caregiver will not be claimed when the participant lives in the caregiver's home or in a residence that is owned or leased by the provider of Medicaid services. <i>The following is an explanation of: (a) the method used to apportion the additional costs of rent and food attributable to the unrelated live-in personal caregiver that are incurred by the individual served on the waiver and (b) the method used to reimburse these costs:</i></p>
<input checked="" type="radio"/>	<p>No. The State does not reimburse for the rent and food expenses of an unrelated live-in personal caregiver who resides in the same household as the participant.</p>

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APPENDIX I-7: Participant Co-Payments for Waiver Services and Other Cost Sharing

- a. **Co-Payment Requirements.** Specify whether the State imposes a co-payment or similar charge upon waiver participants for waiver services. These charges are calculated per service and have the effect of reducing the total computable claim for federal financial participation. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a co-payment or similar charge upon participants for waiver services. <i>(Do not complete the remaining items; proceed to Item I-7-b).</i>
<input type="radio"/>	Yes. The State imposes a co-payment or similar charge upon participants for one or more waiver services. <i>(Complete the remaining items)</i>

- i. **Co-Pay Arrangement** Specify the types of co-pay arrangements that are imposed on waiver participants *(check each that applies)*:

Charges Associated with the Provision of Waiver Services <i>(if any are checked, complete Items I-7-a-ii through I-7-a-iv):</i>	
<input type="checkbox"/>	Nominal deductible
<input type="checkbox"/>	Coinsurance
<input type="checkbox"/>	Co-Payment
<input type="checkbox"/>	Other charge <i>(specify)</i> :

- ii **Participants Subject to Co-pay Charges for Waiver Services.** Specify the groups of waiver participants who are subject to charges for the waiver services specified in Item I-7-a-iii and the groups for whom such charges are excluded

--

- iii. **Amount of Co-Pay Charges for Waiver Services.** In the following table, list the waiver services for which a charge is made, the amount of the charge, and the basis for determining the charge.

Waiver Service	Amount of Charge	Basis of the Charge

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- iv. Cumulative Maximum Charges.** Indicate whether there is a cumulative maximum amount for all co-payment charges to a waiver participant (*select one*):

<input type="radio"/>	There is no cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant.
<input type="radio"/>	There is a cumulative maximum for all deductible, coinsurance or co-payment charges to a waiver participant. Specify the cumulative maximum and the time period to which the maximum applies:

- v. Assurance.** The State assures that no provider may deny waiver services to an individual who is eligible for the services on account of the individual's inability to pay a cost-sharing charge for a waiver service.

- b. Other State Requirement for Cost Sharing.** Specify whether the State imposes a premium, enrollment fee or similar cost sharing on waiver participants as provided in 42 CFR §447.50. *Select one:*

<input checked="" type="radio"/>	No. The State does not impose a premium, enrollment fee, or similar cost-sharing arrangement on waiver participants.
<input type="radio"/>	Yes. The State imposes a premium, enrollment fee or similar cost-sharing arrangement. Describe in detail the cost sharing arrangement, including: (a) the type of cost sharing (e.g., premium, enrollment fee); (b) the amount of charge and how the amount of the charge is related to total gross family income (c) the groups of participants subject to cost-sharing and the groups who are excluded; and, (d) the mechanisms for the collection of cost-sharing and reporting the amount collected on the CMS 64:

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Appendix J: Cost Neutrality Demonstration

Appendix J-1: Composite Overview and Demonstration of Cost-Neutrality Formula

Composite Overview. Complete the following table for each year of the waiver.

Level(s) of Care (<i>specify</i>):			ICF-MR				
Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6	Col. 7	Col. 8
Year	Factor D	Factor D'	Total: D+D'	Factor G	Factor G'	Total: G+G'	Difference (Column 7 less Column 4)
1	\$41,670	\$11,981	\$53,651	\$106,108	\$5,546	\$111,654	\$58,093
2	\$43,517	\$13,035	\$56,552	\$109,292	\$6,093	\$115,385	\$58,833
3	\$45,577	\$14,235	\$59,812	\$112,570	\$6,702	\$119,272	\$59,460
4	\$47,747	\$15,562	\$63,309	\$115,948	\$7,381	\$123,329	\$60,020
5	\$49,889	\$17,032	\$66,921	\$119,426	\$8,139	\$127,565	\$60,644

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Appendix J-2 - Derivation of Estimates

- a. Number Of Unduplicated Participants Served.** Enter the total number of unduplicated participants from Item B-3-a who will be served each year that the waiver is in operation. When the waiver serves individuals under more than one level of care, specify the number of unduplicated participants for each level of care:

Table J-2-a: Unduplicated Participants			
Waiver Year	Total Unduplicated Number of Participants (From Item B-3-a)	Distribution of Unduplicated Participants by Level of Care (if applicable)	
		Level of Care:	Level of Care:
Year 1	585		
Year 2	595		
Year 3	600		
Year 4 (renewal only)	605		
Year 5 (renewal only)	610		

- b. Average Length of Stay.** Describe the basis of the estimate of the average length of stay on the waiver by participants in Item J-2-d.

The average length of stay for the waiver is 324 days.

This figure is actual average length of stay for waiver participants from April 2006 through March 2007.

- c. Derivation of Estimates for Each Factor.** Provide a narrative description for the derivation of the estimates of the following factors.

- i. Factor D Derivation.** The estimates of Factor D for each waiver year are located in Item J-2-d. The basis for these estimates is as follows:

CMS 372 reports serve as the base data. The data has been projected to each renewal year utilizing service-level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007). The managed care organization has also provided utilization estimates by service during the renewal period which were considered alongside the rate setting trends. There are also a few new services for which utilization estimates were the basis for the cost projections. In some cases, such as Financial Supports and Community Guide, the State expects there will be increasingly higher utilization as more waiver recipients choose to self-direct their services. Thus, the percentage of people utilizing these services is expected to increase over the five year renewal period.

- ii. Factor D' Derivation.** The estimates of Factor D' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The State utilized the most recent detailed managed care experience data available to identify other behavioral health costs for waiver participants. This data represented services rendered from April 1, 2005 through March 31, 2006 and was projected to each renewal year utilizing service-

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level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007). This data includes the cost of short term institutionalizations for individuals that returned to the waiver program.

The State also utilized fee-for-service (FFS) data to summarize the historical physical health costs for the waiver participants. This data represented services rendered from April 1, 2005 through March 31, 2006 and was also projected to each renewal year.

Pharmacy costs were adjusted to account for reduced Medicaid expenditures as a result of Medicare Part D effective January 1, 2006. Pharmacy costs were estimated based on expenses incurred by waiver recipients after January 1, 2006.

- iii. Factor G Derivation.** The estimates of Factor G for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The State utilized the most recent detailed managed care experience data available for ICF-MR costs for individuals in the Piedmont area. This data represented services rendered from April 1, 2005 through March 31, 2006 and was projected to each renewal year utilizing service-level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007). This data includes individuals that may have entered the facility while they were a waiver recipient, but never returned to the waiver.

- iv. Factor G' Derivation.** The estimates of Factor G' for each waiver year are included in Item J-1. The basis of these estimates is as follows:

The State utilized the most recent detailed managed care experience data available to identify other behavioral health costs for institutionalized individuals. This data represented services rendered from April 1, 2005 through March 31, 2006 and was projected to each renewal year utilizing service-level trend information from the most recent behavioral health managed care rate setting (for rates effective April 1, 2007).

The State also utilized fee-for-service (FFS) data to summarize the historical physical health costs for individuals residing in ICF-MR facilities. This data represented services rendered from April 1, 2005 through March 31, 2006 and was also projected to each renewal year.

Pharmacy costs were adjusted to account for reduced Medicaid expenditures as a result of Medicare Part D effective January 1, 2006. Pharmacy costs were estimated based on expenses incurred by ICF-MR recipients after January 1, 2006.

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d. Estimate of Factor D. *Select one:* Note: Selection below is new.

<input type="radio"/>	The waiver does not operate concurrently with a §1915(b) waiver. Complete Item J-2-d-i
<input checked="" type="radio"/>	The waiver operates concurrently with a §1915(b) waiver. Complete Item J-2-d-ii

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ii. Estimate of Factor D – Concurrent §1915(b)/§1915(c) Waivers. Complete the following table for each waiver year.

Waiver Year: Year 1						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Communication Devices	<input checked="" type="checkbox"/>	invoice	11	1	\$2,359.70	\$25,957
Natural Supports Education	<input checked="" type="checkbox"/>	15 minutes	5	426	\$9.45	\$20,129
Crisis Continuum	<input checked="" type="checkbox"/>	15 minutes	7	705	\$6.41	\$31,633
Day Supports	<input checked="" type="checkbox"/>	15 minutes	207	3,599	\$4.71	\$3,508,917
Home Supports	<input checked="" type="checkbox"/>	15 minutes	371	5,178	\$5.16	\$9,912,556
Community Networking	<input checked="" type="checkbox"/>	15 minutes	31	1,305	\$16.17	\$654,157
Assistive Technology: Equipment and Supplies	<input checked="" type="checkbox"/>	invoice	46	9	\$254.35	\$105,301
Home Modifications	<input checked="" type="checkbox"/>	invoice	1	1	\$1,538.31	\$1,538
Specialized Consultation Services	<input checked="" type="checkbox"/>	15 minutes	15	15	\$19.89	\$4,475
Vehicle Modifications	<input checked="" type="checkbox"/>	invoice	3	1	\$6,114.76	\$18,344
Financial Supports	<input checked="" type="checkbox"/>	per month	52	14	\$107.16	\$78,012
Community Guide	<input checked="" type="checkbox"/>	15 minutes	52	207	\$9.64	\$103,765
Respite	<input checked="" type="checkbox"/>	15 minutes	316	1,130	\$4.12	\$1,471,170
Community Transition	<input checked="" type="checkbox"/>	invoice	10	1	\$3,214.84	\$32,148
Supported Employment	<input checked="" type="checkbox"/>	15 minutes	62	1,537	\$8.60	\$819,528
Residential Supports	<input checked="" type="checkbox"/>	per day	171	360	\$122.52	\$7,542,331
Individual Goods and Services	<input checked="" type="checkbox"/>	invoice	52	4	\$224.64	\$46,725
GRAND TOTAL:						\$24,376,688
Total: Services included in capitation						\$24,376,688
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						585
FACTOR D (Divide grand total by number of participants)						\$41,670
Services included in capitation						\$41,670
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						324

State:	
Effective Date	

Appendix J: Cost Neutrality Demonstration
HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 2						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Communication Devices	<input checked="" type="checkbox"/>	invoice	12	1	\$2,430.49	\$29,166
Natural Supports Education	<input checked="" type="checkbox"/>	15 minutes	5	435	\$9.73	\$21,163
Crisis Continuum	<input checked="" type="checkbox"/>	15 minutes	7	719	\$6.60	\$33,218
Day Supports	<input checked="" type="checkbox"/>	15 minutes	206	3,669	\$4.71	\$3,559,884
Home Supports	<input checked="" type="checkbox"/>	15 minutes	377	5,278	\$5.16	\$10,267,399
Community Networking	<input checked="" type="checkbox"/>	15 minutes	34	1,330	\$16.65	\$752,913
Assistive Technology: Equipment and Supplies	<input checked="" type="checkbox"/>	invoice	47	9	\$261.98	\$110,818
Home Modifications	<input checked="" type="checkbox"/>	invoice	1	1	\$1,584.45	\$1,584
Specialized Consultation Services	<input checked="" type="checkbox"/>	15 minutes	15	16	\$20.49	\$4,918
Vehicle Modifications	<input checked="" type="checkbox"/>	invoice	3	1	\$6,298.21	\$18,895
Financial Supports	<input checked="" type="checkbox"/>	per month	105	14	\$110.38	\$162,259
Community Guide	<input checked="" type="checkbox"/>	15 minutes	105	211	\$9.93	\$219,999
Respite	<input checked="" type="checkbox"/>	15 minutes	322	1,152	\$4.24	\$1,572,803
Community Transition	<input checked="" type="checkbox"/>	invoice	21	1	\$3,311.28	\$62,537
Supported Employment	<input checked="" type="checkbox"/>	15 minutes	64	1,567	\$8.85	\$887,549
Residential Supports	<input checked="" type="checkbox"/>	per day	174	367	\$126.20	\$8,058,880
Individual Goods and Services	<input checked="" type="checkbox"/>	invoice	105	5	\$231.38	\$121,475
GRAND TOTAL:						\$25,892,457
Total: Services included in capitation						\$25,892,457
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						595
FACTOR D (Divide grand total by number of participants)						\$43,517
Services included in capitation						\$43,517
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						324

State:	
Effective Date	

Appendix J: Cost Neutrality Demonstration
HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 3						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Communication Devices	<input checked="" type="checkbox"/>	invoice	12	1	\$2,503.40	\$30,041
Natural Supports Education	<input checked="" type="checkbox"/>	15 minutes	5	443	\$10.02	\$22,194
Crisis Continuum	<input checked="" type="checkbox"/>	15 minutes	7	733	\$6.80	\$34,891
Day Supports	<input checked="" type="checkbox"/>	15 minutes	204	3,740	\$4.71	\$3,593,542
Home Supports	<input checked="" type="checkbox"/>	15 minutes	380	5,381	\$5.16	\$10,551,065
Community Networking	<input checked="" type="checkbox"/>	15 minutes	36	1,356	\$17.15	\$837,194
Assistive Technology: Equipment and Supplies	<input checked="" type="checkbox"/>	invoice	47	9	\$269.84	\$114,142
Home Modifications	<input checked="" type="checkbox"/>	invoice	1	1	\$1,631.99	\$1,632
Specialized Consultation Services	<input checked="" type="checkbox"/>	15 minutes	15	16	\$21.10	\$5,064
Vehicle Modifications	<input checked="" type="checkbox"/>	invoice	3	1	\$6,487.15	\$19,461
Financial Supports	<input checked="" type="checkbox"/>	per month	159	15	\$113.69	\$271,151
Community Guide	<input checked="" type="checkbox"/>	15 minutes	159	216	\$10.23	\$351,339
Respite	<input checked="" type="checkbox"/>	15 minutes	325	1,174	\$4.37	\$1,667,374
Community Transition	<input checked="" type="checkbox"/>	invoice	32	2	\$3,410.62	\$218,280
Supported Employment	<input checked="" type="checkbox"/>	15 minutes	64	1,597	\$9.12	\$932,137
Residential Supports	<input checked="" type="checkbox"/>	per day	175	374	\$129.98	\$8,507,191
Individual Goods and Services	<input checked="" type="checkbox"/>	invoice	159	5	\$238.32	\$189,464
GRAND TOTAL:						\$27,346,162
Total: Services included in capitation						\$27,346,162
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						600
FACTOR D (Divide grand total by number of participants)						\$45,577
Services included in capitation						\$45,577
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						324

State:	Piedmont North Carolina
Effective Date	April 1, 2008

Appendix J: Cost Neutrality Demonstration
HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 4 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Communication Devices	<input checked="" type="checkbox"/>	invoice	12	1	\$2,578.51	\$30,942
Natural Supports Education	<input checked="" type="checkbox"/>	15 minutes	5	452	\$10.32	\$23,323
Crisis Continuum	<input checked="" type="checkbox"/>	15 minutes	8	747	\$7.00	\$41,832
Day Supports	<input checked="" type="checkbox"/>	15 minutes	201	3,813	\$4.71	\$3,609,805
Home Supports	<input checked="" type="checkbox"/>	15 minutes	383	5,485	\$5.16	\$10,839,896
Community Networking	<input checked="" type="checkbox"/>	15 minutes	39	1,382	\$17.67	\$952,378
Assistive Technology: Equipment and Supplies	<input checked="" type="checkbox"/>	invoice	47	9	\$277.93	\$117,564
Home Modifications	<input checked="" type="checkbox"/>	invoice	1	1	\$1,680.95	\$1,681
Specialized Consultation Services	<input checked="" type="checkbox"/>	15 minutes	15	16	\$21.74	\$5,218
Vehicle Modifications	<input checked="" type="checkbox"/>	invoice	3	1	\$6,681.77	\$20,045
Financial Supports	<input checked="" type="checkbox"/>	per month	214	15	\$117.10	\$375,891
Community Guide	<input checked="" type="checkbox"/>	15 minutes	214	220	\$10.54	\$496,223
Respite	<input checked="" type="checkbox"/>	15 minutes	327	1,197	\$4.50	\$1,761,386
Community Transition	<input checked="" type="checkbox"/>	invoice	43	2	\$3,512.94	\$302,113
Supported Employment	<input checked="" type="checkbox"/>	15 minutes	65	1,628	\$9.39	\$993,650
Residential Supports	<input checked="" type="checkbox"/>	per day	177	382	\$133.88	\$9,052,162
Individual Goods and Services	<input checked="" type="checkbox"/>	invoice	214	5	\$245.47	\$262,653
GRAND TOTAL:						\$28,886,762
Total: Services included in capitation						\$28,886,762
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						605
FACTOR D (Divide grand total by number of participants)						\$47,747
Services included in capitation						\$47,747
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						324

State:	Piedmont North Carolina
Effective Date	April 1, 2008

Appendix J: Cost Neutrality Demonstration
HCBS Waiver Application Version 3.3 – October 2005

Waiver Year: Year 5 (Renewal Only)						
Waiver Service	Col. 1	Col. 2	Col. 3	Col. 4	Col. 5	Col. 6
	Check if included in capitation	Unit	# Users	Avg. Units Per User	Avg. Cost/ Unit	Total Cost
Communication Devices	<input checked="" type="checkbox"/>	invoice	12	1	\$2,655.86	\$31,870
Natural Supports Education	<input checked="" type="checkbox"/>	15 minutes	5	461	\$10.63	\$24,502
Crisis Continuum	<input checked="" type="checkbox"/>	15 minutes	8	762	\$7.21	\$43,952
Day Supports	<input checked="" type="checkbox"/>	15 minutes	199	3,887	\$4.71	\$3,643,246
Home Supports	<input checked="" type="checkbox"/>	15 minutes	386	5,592	\$5.16	\$11,137,922
Community Networking	<input checked="" type="checkbox"/>	15 minutes	41	1,409	\$18.20	\$1,051,396
Assistive Technology: Equipment and Supplies	<input checked="" type="checkbox"/>	invoice	48	10	\$286.27	\$137,410
Home Modifications	<input checked="" type="checkbox"/>	invoice	1	1	\$1,731.38	\$1,731
Specialized Consultation Services	<input checked="" type="checkbox"/>	15 minutes	15	17	\$22.39	\$5,709
Vehicle Modifications	<input checked="" type="checkbox"/>	invoice	3	1	\$6,882.22	\$20,647
Financial Supports	<input checked="" type="checkbox"/>	per month	270	15	\$120.61	\$488,471
Community Guide	<input checked="" type="checkbox"/>	15 minutes	270	224	\$10.85	\$656,208
Respite	<input checked="" type="checkbox"/>	15 minutes	330	1,220	\$4.63	\$1,864,038
Community Transition	<input checked="" type="checkbox"/>	invoice	54	2	\$3,618.33	\$390,780
Supported Employment	<input checked="" type="checkbox"/>	15 minutes	65	1,660	\$9.68	\$1,044,472
Residential Supports	<input checked="" type="checkbox"/>	per day	178	389	\$137.90	\$9,548,472
Individual Goods and Services	<input checked="" type="checkbox"/>	invoice	270	5	\$252.83	\$341,321
GRAND TOTAL:						\$30,432,146
Total: Services included in capitation						\$30,432,146
Total: Services not included in capitation						\$0
TOTAL ESTIMATED UNDUPLICATED PARTICIPANTS (from Table J-2-a)						610
FACTOR D (Divide grand total by number of participants)						\$49,889
Services included in capitation						\$49,889
Services not included in capitation						\$0
AVERAGE LENGTH OF STAY ON THE WAIVER						324

State:	Piedmont North Carolina
Effective Date	April 1, 2008